Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Zolgensma – Medical Necessity Request

1. What diagnosis is Zolgensma being used for?
   - □ Spinal Muscular Atrophy (SMA)
   - □ Other (please specify): _____
2. Is the medication being prescribed by a pediatric neurologist or pediatric geneticist with expertise in the treatment of SMA? **Yes or No**
3. Does the member have bi-allelic mutations in the survival motor neuron 1 (SMN1) gene? ***Provide documentation***. **Yes or No**
4. Will the member's liver function be assessed prior to administration of Zolgensma and for at least 3 months after infusion? **Yes or No**
5. Will the member be receiving other surviving motor neuron (SMN) modifying therapy (e.g., Spinraza®) together with Zolgensma? **Yes or No**
6. Does the member have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence)? **Yes or No**
7. Has baseline anti-adeno-associated virus serotype 9 (anti-AAV9) antibody testing been done and titers are ≤ 1:50? **Yes or No**
8. Will the member receive systemic corticosteroid equivalent to oral prednisolone 1mg/kg/day at least 1 day prior to Zolgensma infusion and will continue to receive corticosteroid therapy for at least a total of 30 days ? **Yes or No**
9. Has the member previously received Zolgensma in their lifetime? **Yes or No**
10. What is the member's current weight? _____lbs OR _____kg

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**