STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PO BOX 2943 HARTFORD, CT 06104
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110
Letters of Medical Necessity: Rx.LMN@CT.GOV

CT Medical Assistance Program Evrysdi™ (risdiplam) Authorization (PA) Request Form

[This and other pharmacy PA forms are available at www.ctdssmap.com]

To Be Completed By Prescriber

Prescriber Information	**Patient Information**
Prescriber Name:	Client Name:
Prescriber's NPI:	Client ID Number:
Phone # ( )	Patient DOB:
Fax # ( )	Primary ICD diagnosis code:
Prescription Information	
Drug Requested:	Dose/frequency:
	Expected Duration:

Clinical Information

When all questions below have been answered with "Yes" indicating criteria for coverage has been met, please fax this form to the fax number listed at the top of this form. An initial authorization will be given for twelve (12) months only. The provider listed in box 1 of this form agrees to monitor the patient over the entire course of treatment for positive responses and will discontinue this medication in the event a positive response is not observed.

*****If ANY of the questions below are answered with "No", a Letter of Medical Necessity must be submitted to the Department of Social Services via email Rx.lmn@ct.gov for consideration. *****

Does patient have a diagnosis of spinal muscular atrophy (SMA)?	□ Yes □ No
The patient is **NOT** receiving concomitant chronic survival motor neuron (SMN) modifying therapy i.e., SPINRAZA® (nusinersen)?	□ Yes □ No
If patient has previously received gene replacement therapy with ZOLGENSMA® (onasemnogene abeparvovci-xioi), has there been a decline in clinical status (i.e., loss of motor milestone(s))?	□ Yes □ No

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1-13 and 4a-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the client is under my clinic's/practice's ongoing care. I certify that I am a physician and hold a current, unrestricted license to practice medicine and that I am enrolled in the CT Medical Assistance Program.

Prescriber Signature:_____ **Date:**_____