Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2021-28**
www.ctdssmap.com **April 2021**

TO: **Pharmacy Providers, Physicians, Nurse Practitioners, Physician Assistants, Clinics, Long Term Care Providers, and Hospitals**
RE: **New Prior Authorization Requirement for Evrysdi**

Effective June 1, 2021, the Department of Social Services (DSS) will implement a Prior Authorization (PA) requirement for prescription benefit coverage of Risdiplam, marketed as Evrysdi ™, for HUSKY A, HUSKY B, HUSKY C, and HUSKY D.

The U.S Food and Drug Administration (FDA) has approved Risdiplam for the treatment of spinal muscular atrophy (SMA) in patients two (2) months of age and older. SMA is a hereditary disease that causes weakness and muscle wasting due to the loss of lower motor neurons responsible for controlling movement. Risdiplam is the first oral agent indicated for SMA.

Prior Authorization (PA) Requirements

Clinical criteria for PA approval for Rispaldam is as follows:

1. The patient must be age 2 months or older;
2. The patient must have a diagnosis of spinal muscular atrophy (SMA);
3. The patient is **NOT** receiving concomitant chronic survival motor neuron (SMN) modifying therapy, i.e. Spinraza ™ (nusinersen);
4. The patient has a documented decline in functional status related to SMA (i.e. loss of motor milestone(s)) in patients who have previously received gene replacement therapy with Zolgensma™ (onasemnogene abeparvovci-xioi).

In instances where the individual does not meet these criteria, the prescriber must write a letter of medical necessity to DSS' Medical Director for consideration. Letters of medical necessity can be emailed **with the Evrysdi PA form** to Rx.LMN@ct.gov.

The new Evrysdi PA Form is attached below and will be available on the www.ctdssmap.com Web site. From the Home page, go to Information > Publications > Authorization/Certification Forms > Evrysdi PA Form; or from the Home page, go to Pharmacy Information > Pharmacy Program Publications > Evrysdi PA Form.

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PO BOX 2943 HARTFORD, CT 06104
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035
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. *****

Is the patient the age of two (2) months or older?	□ Yes □ No
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

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:_____