ambetter. FROM peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Onasemnogene abeparvovec (Zolgensma)
PDAC Drug Review Form

The information below can be completed by the Health Plan and/or Centene Pharmacy Services (CPS) staff

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: / /
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information

*Primary Insurance (Health Plan Name and State)	*ID #:

Physician Information

*Name:	*Specialty:	*Phone #:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Spinal muscular atrophy (SMA) type 1 ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Zolgensma (Onasemnogene abeparvovec)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY Start Date**: _____

1. Is therapy prescribed by or in consultation with a neurologist? ☐Yes ☐No
2. Did patient have onset of symptoms prior to 6 months of age? ☐Yes ☐No
3. Does genetic testing quantifying number of copies of survival motor neuron 2 (SMN2) gene confirm any of the following? ☐Yes ***Mark all that apply**** ☐No
   - ☐1, 2, or 3 copies of SMN2 gene
   - ☐4 copies of SMN2 gene, determined by a quantitative assay that is able to distinguish between four SMN2 gene copies and five or more SMN2 gene copies
4. Does genetic testing confirm any of the following? ☐Yes ***Mark all that apply**** ☐No
   - ☐Homozygous deletions of SMN1 gene (e.g., absence of the SMN1 gene)
   - ☐Homozygous mutation in the SMN1 gene (e.g., biallelic mutations of exon 7)
   - ☐Compound heterozygous mutation in the SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
5. Please document the following patient information:
   a. Patient's weight: _____ kg
   b. Baseline Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score: _____
   c. Baseline Hammersmith Infant Neurological Examination (HINE) motor milestone score: _____
   d. Baseline laboratory tests demonstrating Anti-AAV9 antibody titers ≤1:50 as determined by ELISA binding immunoassay: _____
   e. Baseline liver function test: _____ , platelet counts: _____ , troponin-I: _____
6. Does patient have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence for 16 or more hours per day, tracheostomy, non-invasive ventilation beyond the use for sleep)? ☐Yes ☐No
7. Has patient been previously treated with Zolgensma? ☐Yes ☐No
8. Is Zolgensma prescribed concurrently with Spinraza or Evrysdi? ☐Yes ☐No
9. Is patient currently on Spinraza? ☐Yes ***Must submit documentation & mark all that apply**** ☐No
   - ☐Evidence of clinical deterioration upon completion of all loading doses of Spinraza (e.g., sustained decrease in CHOP-INTEND score over a period of 3 to 6 months) upon completion of all loading doses of Spinraza
   - ☐Spinraza is being used as a bridge therapy to Zolgensma
   - ☐Provider attestation of clinical deterioration and Spinraza discontinuation
10. Is patient currently on Evrysdi? ☐Yes ***Must submit documentation & mark all that apply**** ☐No
    - ☐Evidence of clinical deterioration (e.g., sustained decrease in CHOP-INTEND score over a period of 3 to 6 months)
    - ☐Evrysdi is being used as a bridge therapy to Zolgensma
    - ☐Provider attestation of clinical deterioration and Evrysdi discontinuation
11. Does patient have an active viral infection? ☐Yes ***Mark all that apply**** ☐No

PDAC updated: 09/08/2025
AMB25-GA-HP-00216

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☐HIV ☐Hepatitis B ☐Hepatitis C ☐Zika ☐Upper/lower respiratory tract infection
☐Non-respiratory tract infection ☐Other: _____

12. How many Zolgensma infusions has patient received? ☐0 ☐≥ 1

Please continue to page 2.

Patient Name: _____ **DOB:** _____

Complete this section ONLY for indications other than SMA:

13. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No

If yes, submit documentation and answer the following:

a. Please list all previous therapies: _____
b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Information	
***Number:**	***Date of Request:**
***HCPCS Code:**	***Decision Due Date:**
* **Line of Business:** ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	* **Benefit:** ☐ Medical ☐ Pharmacy

*** Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐ Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐ Centene Policy [**CP.PHAR.421 Onasemnogene Abeparvovec (Zolgensma)]**
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):

_____

OR

☐ State or Health Plan Specific (please include policy)