

<input type="checkbox"/>	<p>If the patient is a premature neonate, full-term gestation age of 39 weeks and 0 days has been met</p> <p>Note: Full-term gestational age can be defined as the postmenstrual age (gestational age plus chronological age) being equal to ≥ 39 weeks and 0 days.</p>
<input type="checkbox"/>	<p>Patient has not received Zolgensma or Itvisma (onasemnogene abeparvovec-brve intrathecal injection) in the past</p> <p>Note: If no claim for Zolgensma or Itvisma is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Zolgensma or Itvisma.</p>
<input type="checkbox"/>	<p>Patient has had a genetic test confirming the diagnosis of spinal muscular atrophy with bi-allelic pathogenic variants in the survival motor neuron 1 (SMN1) gene [documentation required]</p> <p>Note: Pathogenic variants may include homozygous deletion, compound heterozygous mutation, or a variety of other rare mutations</p>
<input type="checkbox"/> i. <input type="checkbox"/> ii-a. <input type="checkbox"/> ii-b.	<p>Patient meets ONE of the following (i or ii):</p> <p>i. Patient has three or fewer survival motor neuron 2 (SMN2) gene copies [documentation required]</p> <p>ii. Patient meets BOTH of the following (a and b):</p> <p>a) Patient has four SMN2 gene copies [documentation required]</p> <p>b) The number of SMN2 gene copies has been determined by a quantitative assay capable of distinguishing between four SMN2 gene copies and five or greater SMN2 gene copies</p>
<input type="checkbox"/>	<p>Baseline anti-AAV9 antibody titers are $\leq 1:50$ [documentation required]</p>
<input type="checkbox"/> i. <input type="checkbox"/> ii. <input type="checkbox"/> iii. <input type="checkbox"/> iv.	<p>Patient has undergone liver function testing within the past 30 days and meets ALL of the following (i, ii, iii, and iv):</p> <p>i. Alanine aminotransferase levels are ≤ 2 times the upper limit of normal [documentation required]</p> <p>ii. Aspartate aminotransferase levels are ≤ 2 times the upper limit of normal [documentation required]</p> <p>iii. Total bilirubin levels are ≤ 2 times the upper limit of normal [documentation required]</p> <p>Note: Patient with elevated bilirubin levels due to neonatal jaundice are acceptable.</p> <p>iv. Prothrombin time results are ≤ 2 times the upper limit of normal [documentation required]</p> <p>Date of completed lab(s):</p>
<input type="checkbox"/>	<p>Patient has undergone a renal function assessment within the past 30 days and has a creatinine level < 1.0 mg/dL [documentation required]</p> <p>Date of completed lab:</p>
<input type="checkbox"/> i. <input type="checkbox"/> ii.	<p>A complete blood count has been obtained within the past 30 days and the patient meets BOTH of the following (i and ii):</p> <p>i. White blood cell count is $\leq 20,000$ cells per mm^3 [documentation required]</p> <p>ii. Hemoglobin level is within the normal reference range [documentation required]</p> <p>Note: Reference ranges for hemoglobin levels vary among laboratories and are dependent upon age and gender.</p> <p>Date of completed lab(s):</p>
<input type="checkbox"/>	<p>For a patient currently receiving or who has received prior treatment with Spinraza (nusinersen intrathecal injection), the prescribing physician confirms that further therapy with Spinraza will be discontinued</p>
<input type="checkbox"/>	<p>For a patient currently receiving or who has received prior treatment with Evrysdi (risdiplam oral solution and tablets), the prescribing physician confirms that further therapy with Evrysdi will be discontinued</p>
<input type="checkbox"/>	<p>The medication is prescribed by a physician who has consulted with or who specializes in the management of patients with spinal muscular atrophy and/or neuromuscular disorders</p>
<input type="checkbox"/>	<p>Current patient body weight has been obtained within the past 14 days [documentation required]</p> <p>Date obtained:</p>
<input type="checkbox"/>	<p>Patient has complete paralysis of all limbs</p>
<input type="checkbox"/>	<p>Patient has permanent ventilator dependence</p>
<input type="checkbox"/>	<p>Prior receipt of gene therapy.</p>

If any of the requirements listed above are not met and you feel administration of the requested gene therapy is medically necessary, please provide clinical support and rationale for the use of this gene therapy.

Additional pertinent information: (including recent history and physical, recent lab work, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)

Additional CPT and/or Administration Codes for Billing.

Other

Agreement and Attestation:

Do you and your patient agree to share any required plan specific outcome measures? Yes No

I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Coverage Policies online at cigna.com.

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