TEXAS MEDICAID
Clinical Edit Prior Authorization
risdiplam (EVRYSDI) – Initial Requests

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Does the client have a diagnosis of spinal muscular atrophy (SMA) type 1, 2 or 3 in the last 730 days? **(Supporting documentation must be provided along with baseline motor function tests)**

   Note: Diagnosis of spinal muscular atrophy (SMA), confirmed by SM1 gene mutation or deletion. Testing tools that can be used to demonstrate physical function include, but are not limited to:

   - The Hammersmith Infant Neurological Exam (HINE)

   - The Hammersmith Functional Motor Scale Expanded (HFSME)

   - The Upper Limb Module (UML) or revised Upper Limb Module (RULM)

   - Baseline 6MWT

   - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Is the client between 2 months and 65 years of age?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Is the client pregnant?

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a diagnosis of hepatic impairment?

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Is the requested dose less than or equal to (≤) 5mg per day?

☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.