Horizon NJ Health
Zolgensma – Medical Necessity Request

1. What diagnosis is Zolgensma being used for?
   □ Spinal Muscular Atrophy (SMA)
   □ Other (please specify): _______________________________

2. Is the medication being prescribed by or in consultation with a pediatric neurologist or geneticist with expertise in the treatment of SMA?  __Yes__ or __No__

3. Does the member have bi-allelic mutations in the survival motor neuron 1 (SMN1) gene? _Provide documentation._ __Yes__ or __No__

4. Will the member be receiving other surviving motor neuron (SMN) modifying therapy (e.g., Spinraza®) together with Zolgensma? __Yes__ or __No__

5. Does the member have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence)? __Yes__ or __No__

6. Will the member’s liver function be assessed prior to administration of Zolgensma? __Yes__ or __No__

7. Will the member receive systemic corticosteroid equivalent to oral prednisolone 1mg/kg/day at least 1 day prior to Zolgensma infusion and will continue to receive corticosteroid therapy for at least a total of 30 days? __Yes__ or __No__

8. Has the member previously received Zolgensma in their lifetime? __Yes__ or __No__

9. What is the member’s current weight? _____ lbs OR _____ kg

*Form must be completed and signed by physician or licensed representative from the physician’s office*