curative

Risdiplam Prior Authorization

Drug(s) Applied:	**Evrysdi** (risdiplam)

Criteria:
Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

I. Initial Therapy Criteria
- **A. Spinal Muscular Atrophy (SMA)** as indicated by chart notes within past 120 days
  1. Diagnosis of SMA type 1 **and**
  2. Diagnosis is confirmed by genetic testing showing bi-allelic mutations in the SMN1 gene (homozygous deletion, homozygous mutation, or compound heterozygous mutation) **and**
  3. SMN2 copy count of 2 or more **and**
  4. At least ONE of the following functional assessments at baseline:
     a) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
     b) Hammersmith Infant Neurological Examination (HINE)
     c) Hammersmith Functional Motor Scale – Expanded (HFMSE)
     d) Bayley Scales of Infant and Toddler Development (BSID)
     e) Motor Function Measurement score (MFM32) **and**
  5. Patient does not require invasive ventilation or tracheostomy **and**
  6. Patient has not received gene therapy for SMA (e.g., Zolgensma) **and**
  7. Patient will NOT be using the requested agent in combination with Spinraza (nusinersen) and has not received Spinraza in the last four (4) months **and**
  8. Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurology, geneticist)

Approval Duration: 12 months

II. Continued Therapy Criteria
- **A. Spinal Muscular Atrophy (SMA)** as indicated by chart notes within past 12 months
  1. Patient has been previously approved for the requested agent through the plan's Prior Authorization process or meets the initial therapy criteria above **and**
  2. Documented clinical benefit since starting the requested agent as indicated by ONE of the following functional assessments showing improvements or

stabilization from baseline:

a) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
b) Hammersmith Infant Neurological Examination (HINE)
c) Hammersmith Functional Motor Scale – Expanded (HFMSE)
d) Bayley Scales of Infant and Toddler Development (BSID)
e) Motor Function Measurement score (MFM32) **and**

3. Patient does not require invasive ventilation or tracheostomy **and**
4. Patient has not received gene therapy for SMA (e.g., Zolgensma) **and**
5. Patient will NOT be using the requested agent in combination with Spinraza (nusinersen) **and**
6. Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurology, geneticist)

Approval Duration: 12 months

Policy Owned by: Curative PBM team