

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

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 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 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**
7. Has the member previously received Zolgensma in their lifetime? **Yes or No**
8. What is the member's current weight? _____ lbs OR _____ kg

Physician office's signature* _____ Print Name _____
*Form must be completed and signed by physician or licensed representative from the physician's office