Clinical Criteria Worksheet:
Zolgensma® (abeparvovec-xioi)

Enrollee Information

Enrollee Last Name: ______________________

Enrollee First Name: ______________________

Date of Birth (MM/DD/YYYY): __ __ / __ __ / __ __ __ __

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): __ __ __ __ __ __ __ __

Address: ____

City, Town or Post Office: ______________________

State: ______

ZIP Code: __________

Prescriber Information

Prescriber Last Name: ______________________

Prescriber First Name: ______________________

National Provider Identifier (NPI) Number: ______________________

Preferred Contact (Telephone Number): ______________________

Clinical Criteria – Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY):

__ __ / __ __ / __ __ __ __

Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY):

__ __ / __ __ / __ __ __ __

Drug Name and Strength:

Number of vials used: ______________________

Patient Weight (in kilograms):______________________

Directions: ____

Enrollee Last Name: ____________________ **Enrollee First Name:** ____________________

Clinical Criteria – Diagnosis

1. Zolgensma® will be approved for one treatment per patient for their lifetime. Has the patient received any prior doses of Zolgensma®?

   ☐ Yes ☐ No

2. Does the patient have documented genetic testing confirming the presence of bi-allelic mutations in the SMN1 gene?

   ☐ Yes ☐ No

   If **Yes**, please provide the date of the lab test result:

   ☐☐ / ☐☐ / ☐☐☐☐

3. Will the patient will be taking risdiplam or nusinersen after administration of Zolgensma? (concurrent use will not be approved)

   ☐ Yes ☐ No

4. Is the patient less than 2 years of age?

   ☐ Yes ☐ No

5. For neonatal patients born prematurely, has full-term (40 weeks) corrected gestational age been reached?

   ☐ Yes ☐ No ☐ Not Applicable

   *If No, Delay ZOLGENSMA infusion until full-term gestational age is reached.

6. Does the patient have complete limb paralysis?

   ☐ Yes ☐ No

7. Does the patient have permanent ventilator dependence*?

   ☐ Yes ☐ No

   **defined as requiring invasive ventilation (tracheostomy) or respiratory assistance for 16 or more hours per day (including noninvasive ventilator support) continuously for 14 or more days in the absence of an acute reversible event, excluding perioperative ventilation*

Attestation

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

Prescriber Signature (Required) ____________________ **Date (MM/DD/YYYY)** ____________________