Clinical Criteria Worksheet:
Zolgensma® (abeparvovec-xioi)

Claim Submission

- Claim processing may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
- A claim should not be submitted until the drug has been administered to the patient.
- The manufacturer invoice showing the acquisition cost of the drug administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the drug, or it will be rejected for not enough documentation.

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)

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Enrollee Last Name: | | | | | | | | | | | | |

Enrollee First Name: | | | | | | | | | | | | |

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:

☐ ZOLGENSMA KIT

Patient Weight (in kilograms):_____

Directions: _____

Quantity: _____

Clinical Criteria – Diagnosis

1. ☐ Spinal Muscular Atrophy with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene

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

   ☐ Yes ☐ No

3. Does the patient have documented genetic testing confirming the presence of bi-allelic mutations in the SMN1 gene and three copies or less of the SMN2 gene?

   ☐ Yes ☐ No

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

		/			/				

Enrollee Last Name:

Enrollee First Name:

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

6. Does the patient have a baseline anti-AAV9 (Adeno-associated virus) antibody titer of ≤ 1:50 prior to administration?

   ☐ Yes ☐ No

7. Does the patient have complete limb paralysis?

   ☐ Yes ☐ No

8. 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)**