ALBERTA BLUE CROSS®

NUSINERSEN/ RISDIPLAM
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Drug Requested ☐ Nusinersen (e.g. Spinraza) ☐ Risdiplam (e.g. Evrysdi)

Diagnosis	**Please indicate if this patient is**	
☐ 5q Spinal Muscular Atrophy (SMA) ☐ Other (specify) _____	☐ starting drug upon approval …….. **complete section I** ☐ new to coverage but currently maintained on drug …..**complete section I and II** ☐ submitting renewal request ……..**complete section II**	
Dosage and frequency requested	Treatment start date	Date of last dose

Previous therapy: 1) Has the patient received an adeno-associated virus (AAV) vector-based gene therapy? ☐ Yes, Date _____ ☐ No
2) Please indicate if the patient will be using the requested drug in combination with other drugs for the treatment of SMA ☐ Yes ☐ No

Section I: Please provide <u>pre-treatment</u> information for all INITIAL requests for treatment naive and treatment experienced patients

Confirmation of diagnosis (Note: copy of the test report must be provided)

For Nusinersen: Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote ☐ Yes ☐ No

For Risdiplam: Genetic documentation of 5q SMA homozygous gene deletion or compound heterozygote ☐ Yes ☐ No

Disease Onset and Duration: Please check which of the following applies (check ONE only)

Nusinersen (**Note: copy of the test report must be provided)**

☐ Pre-symptomatic with two or three copies of the Survival Motor Neuron 2 (SMN2) gene

☐ Disease duration of less than 6 months, two copies of SMN2, and symptom onset after the first week after birth and on or before 7 months of age

☐ Under the age of 18 with symptom onset after 6 months of age, regardless of the ability to walk independently

Risdiplam (Note: copy of the test report must be provided)

☐ Symptomatic with two or three copies of the SMN2 gene, age 2 to 7 months (inclusive)

☐ Symptomatic with two or three copies of the SMN2 gene, age 8 months to 25 years (inclusive) and non-ambulatory

Disease duration at treatment initiation _____	Age of onset of clinical signs and symptoms consistent with SMA _____	Were symptoms present at birth? ☐ Yes ☐ No

Ventilation status: Patient requires permanent invasive ventilation* at treatment initiation? ☐ Yes ☐ No

* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Age-Appropriate Motor function score – Provide at least one of the following PRE-TREATMENT scores

a) Hammersmith Infant Neurological Examination [HINE] Section 2 pre-treatment score _____ Date _____

b) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND] pre-treatment score _____ Date _____

c) Hammersmith Functional Motor Scale-Expanded [HFMSE] pre-treatment score _____ Date _____

Section II: Please complete the following for all RENEWAL requests and for INITIAL requests for treatment experienced patients

Age-Appropriate Motor function score – Provide at least one of the following CURRENT RESPONSE scores

a) Hammersmith Infant Neurological Examination [HINE] Section 2 response score _____ Date _____

b) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND] response score _____ Date _____

c) Hammersmith Functional Motor Scale-Expanded [HFMSE] response score _____ Date _____

Ventilation status: Patient currently requires permanent invasive ventilation*? ☐ Yes ☐ No

* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX: 780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST