Onasemnogene Abeparvovec (Zolgensma) Request Form

Full Name		CCS Case #	Date Completed:
County		DOB	
Patient ID		SMA Type:	
SMN1 mutation (and laboratory name):			
Number of SMN2 copies (and laboratory name):			
Other medical condition(s):			
Clinical Status:			**Comments:**
Age:			Must be < 2 years of age
Evidence of advanced Disease: (As demonstrated by a "Y" to any of the 3 below)			Must NOT have advanced disease.
Invasive ventilator support? (Y/N):			
Complete limb paralysis? (Y/N):			
Unable to feed orally? (Y/N)			
AAV9 titer < 1:50			High titers of antibodies preclude use.
Neuromuscular Assessment:			Used to establish clinical baseline
Baseline Labs: (include results and date of testing below)			
LFTs:			
Platelet Count:			
Troponin-I:			
Is patient currently being treated with nusinersen? (Y/N)			Nusinersen treatment must be stopped.
Has patient previously been treated with Onasemnogene abeparvovec? (Y/N)			Can only be treated one time.
Form Completed By (Name/Title):			Date Completed
Special Care Facility Name:			
To be completed by CCS staff			
Approved ☐ Denied ☐ Reason for Denial:			Date:
Reviewed By (ISCD staff)			