

**SPINRAZA (nusinersen) PRIOR AUTHORIZATION FORM**

Prior authorization guidelines and quantity limits are located in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Spinraza** accessible on the Department’s Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacy/services/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact’s phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

**CLINICAL INFORMATION**

<b>Medication:</b> Spinraza 12 mg/5 ml vial	<b>Quantity:</b> _____ 12 mg/5 ml vials	<b>Refills:</b>
<b>Directions:</b> <input type="checkbox"/> loading dose: 12 mg (1 vial) every 14 days x 3 doses, then 12 mg (1 vial) 30 days after 3 <sup>rd</sup> dose <input type="checkbox"/> maintenance dose: 12 mg (1 vial) every 4 months <input type="checkbox"/> other: _____		
<b>Diagnosis:</b>	<b>Dx code (required):</b>	<b>Weight:</b> _____ lbs / kg

**INITIAL REQUESTS**

1. Does the recipient have a diagnosis of spinal muscular atrophy (SMA) type I, II, or III with the corresponding mutation or deletion in the SMN gene found at chromosome 5q13?	<input type="checkbox"/> Yes – <u>submit documentation of diagnosis.</u> <input type="checkbox"/> No – <u>submit medical literature supporting the use of Spinraza for the recipient’s diagnosis.</u>
2. Is Spinraza prescribed by or in consultation with a neurologist with experience treating SMA?	<input type="checkbox"/> Yes <u>Submit documentation of consultation with specialist, if applicable.</u> <input type="checkbox"/> No
3. Did the recipient have a baseline evaluation, including a standardized assessment of motor function (eg, HINE, ULM, etc.), by a neurologist with experience treating SMA?	<input type="checkbox"/> Yes <u>Submit documentation of baseline evaluation and assessment.</u> <input type="checkbox"/> No
4. Does the recipient have a documented baseline platelet count, and will a platelet count be repeated prior to each dose?	<input type="checkbox"/> Yes <u>Submit documentation.</u> <input type="checkbox"/> No
5. <u>Submit documentation</u> of the recipient’s comprehensive treatment regimen, such as nutritional support, physical therapy, respiratory care, etc.	

**RENEWAL REQUESTS**

1. Is Spinraza prescribed by or in consultation with a neurologist with experience treating spinal muscular atrophy (SMA)?	<input type="checkbox"/> Yes <u>Submit documentation of consultation with specialist, if applicable.</u> <input type="checkbox"/> No
2. Did the recipient have an annual evaluation, including a standardized assessment of motor function (eg, HINE, ULM, etc.), by a neurologist with experience treating SMA?	<input type="checkbox"/> Yes <u>Submit documentation of annual evaluation and assessment.</u> <input type="checkbox"/> No
3. Is the recipient experiencing clinical benefit from Spinraza?	<input type="checkbox"/> Yes <u>Submit documentation.</u> <input type="checkbox"/> No
4. Does the recipient have a documented platelet count prior to each dose?	<input type="checkbox"/> Yes <u>Submit documentation.</u> <input type="checkbox"/> No
5. <u>Submit documentation</u> of the recipient’s comprehensive treatment regimen, such as nutritional support, physical therapy, respiratory care, etc.	

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b>	<b>Date:</b>
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