pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SPINRAZA (nusinersen) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Spinraza (nusinersen) are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug: Spinraza 12 mg/5 ml vial		# of vials per dose: _____ 12 mg/5 ml vials
Directions:	☐loading dose: 12 mg (1 vial) every 14 days x 3 doses ☐maintenance dose: 12 mg (1 vial) every 4 months ☐other: _____	# of initial doses requested: _____ # of maintenance doses requested: _____
Diagnosis:	*Dx code (required)*:	Weight: _____ kg
Is Spinraza prescribed by or in consultation with a neurologist with experience treating SMA?	☐Yes ☐No	*Submit documentation of consultation with specialist, if applicable.*
Will the beneficiary be using Evrysdi in addition to Spinraza?	☐Yes ☐No	*Submit complete medication list.*
Submit documentation of the beneficiary's comprehensive treatment regimen, such as nutritional support, physical therapy, respiratory care, etc.		
INITIAL Requests		
Does the beneficiary have a diagnosis of spinal muscular atrophy (SMA) with the corresponding mutation or deletion in the SMN gene found at chromosome 5q13?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of Spinraza for the beneficiary's diagnosis.*	
Did the beneficiary have a baseline evaluation, including a standardized assessment of motor function (eg, HINE, ULM, etc.), by a neurologist with experience treating SMA?	☐Yes ☐No	*Submit documentation of baseline evaluation and assessment.*
Does the beneficiary have a documented baseline platelet count, and will a platelet count be repeated prior to each dose?	☐Yes ☐No	*Submit documentation.*
RENEWAL Requests		
Did the beneficiary have an annual evaluation, including a standardized assessment of motor function (eg, HINE, ULM, etc.), by a neurologist with experience treating SMA?	☐Yes ☐No	*Submit documentation of annual evaluation and assessment.*
Is the beneficiary experiencing clinical benefit from Spinraza?	☐Yes ☐No	*Submit documentation.*
Does the beneficiary have a documented platelet count prior to each dose?	☐Yes ☐No	*Submit documentation.*

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

Prescriber Signature:	Date: