

## Spinraza<sup>®</sup> (nusinersen) Prior Authorization Form

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

### Drug Information

**Physician billing (HCPCS code:** \_\_\_\_\_)  **Pharmacy billing (NDC:** \_\_\_\_\_)

**Start Date (or date of next dose):** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_

### Billing Provider Information

**Provider NPI:** \_\_\_\_\_ **Provider Name:** \_\_\_\_\_

**Provider Phone:** \_\_\_\_\_ **Provider Fax:** \_\_\_\_\_

**Name of outpatient hospital facility where Spinraza will be delivered to and administered at:**

### Prescriber Information

**Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_

**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

### Criteria

**\*Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.**

**For Initial Authorization (Initial approval will be for the duration of 6 months):**

- Has the member previously been treated with Spinraza<sup>®</sup>? Yes \_\_\_ No \_\_\_
  - If yes, please provide dates of previous doses: \_\_\_\_\_
- What is the member's diagnosis?
  - Spinal Muscular Atrophy (SMA)**
    - What type of SMA does the member have (0-4)? \_\_\_\_\_
    - Does member currently have symptoms consistent with SMA? Yes \_\_\_ No \_\_\_
    - Has the diagnosis been confirmed by molecular genetic testing? Yes \_\_\_ No \_\_\_
      - If yes, please submit results of genetic testing.
    - Does member have biallelic pathogenic variants in the survival motor neuron gene 1 (*SMN1*)? Yes \_\_\_ No \_\_\_
  - Other:** \_\_\_\_\_
- Is member currently dependent on permanent ventilation? Yes \_\_\_ No \_\_\_
  - If yes, please specify number of hours per day member requires ventilator support: \_\_\_\_\_
- Is Spinraza<sup>®</sup> prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA)? Yes \_\_\_ No \_\_\_
- Has member previously received treatment with Zolgensma<sup>®</sup>? Yes \_\_\_ No \_\_\_
- Has member previously been treated with Evrysdi<sup>®</sup>? Yes \_\_\_ No \_\_\_
  - If yes, will Evrysdi<sup>®</sup> be discontinued upon approval of Spinraza<sup>®</sup>? Yes \_\_\_ No \_\_\_
- Has platelet count, coagulation laboratory testing, and quantitative spot urine protein testing been obtained? Yes \_\_\_ No \_\_\_
  - If yes, are levels acceptable to the prescriber? Yes \_\_\_ No \_\_\_

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**PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit  
Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

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**Spinraza® (nusinersen) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Criteria**

**\*Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.**

**For Initial Authorization (continued):**

8. Does prescriber agree to do a platelet count, coagulation testing, and quantitative spot urine protein testing prior to each dose? Yes\_\_\_\_ No\_\_\_\_
9. Will Spinraza® be administered in a health care facility by a specialist experienced in performing lumbar punctures? Yes\_\_\_\_ No\_\_\_\_
10. Has a baseline assessment been performed and documented using at least 1 of the following exams as functionally appropriate: Hammersmith Infant Neurological Exam (HINE), Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Upper Limb Module (ULM) Test, or Hammersmith Functional Motor Scale Expanded (HFMSE)]? Yes\_\_\_\_ No\_\_\_\_
  - A. If yes, please indicate the exam performed: \_\_\_\_\_
  - B. Please provide member’s baseline score to exam listed above: \_\_\_\_\_

**For Continued Authorization:**

1. Is member responding to the medication as demonstrated by a clinically significant improvement or maintenance of function from pre-treatment baseline status using the same exam as performed at baseline assessment? Yes\_\_\_\_ No\_\_\_\_
2. Please indicate exam used to perform assessment: \_\_\_\_\_
  - A. Please provide member’s baseline score to exam listed above: \_\_\_\_\_
  - B. Please provide member’s current score to exam listed above: \_\_\_\_\_
3. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support: \_\_\_\_\_

**Additional Information:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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