PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Spinraza (nusinersen)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:		**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Group Number:		NPI:	State Lic ID:
Address:	Address:		
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. For what diagnosis is the drug being prescribed (pick one)?

- ☐ Spinal muscle Atrophy (SMA) Type I
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Please indicate location of administration.

- ☐ Home
- ☐ Long Term Care (LTC) facility
- ☐ Physician office (drug from office stock - buy and bill)
- ☐ Physician office (drug from pharmacy with a prescription)

Q4. Is the prescriber a Neurologist with expertise in the diagnosis and/or treatment of spinal muscle atrophy (SMA)?

☐ Yes ☐ No

Q5. Was the diagnosis of SMA type I made before 6 months of age?

☐ Yes ☐ No

Q6. Was diagnosis of SMA type I confirmed by 5q SMA homozygous gene deletion of homozygous mutation OR

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compound heterozygous mutation? (Please provide documentation)

☐ Yes ☐ No

Q7. Was diagnosis of SMA type I confirmed by the presence of no more than 2 copies of survival motor neuron 2 (SMNs)? (Please provide documentation)

☐ Yes ☐ No

Q8. Is the patient dependent on any of the following? (Select all that apply)

- ☐ Invasive ventilation
- ☐ Tracheostomy
- ☐ Non-invasive ventilation for more than 6 hours per day
- ☐ None of the above

Q9. Is request accompanied by baseline motor ability testing using either: Hammersmith Infant Neurological Exam (HINE) OR Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP INTEND)?

☐ Yes ☐ No

Q10. Is Spinraza dosed in accordance with FDA labeling?

☐ Yes ☐ No

Q11. For continuation of therapy, is request accompanied by assessment of motor ability testing using either HINE or CHOP INTEND that shows improvement in at least one of the following (Select all that apply and submit documentation)

- ☐ HINE: improvement or maintenance of previous improvement of at least 2 point (or maximum score) increase in ability to kick
- ☐ HINE: Improvement or maintenance or previous improvement of at least 1 point increase in motor milestones of head control, rolling, sitting, crawling, standing, or walking
- ☐ HINE: Improvement in more categories of motor milestones than worsening
- ☐ CHOP-INTEND: Improvement or maintenance of previous improvement of at least a 4 point increase in score from pretreatment baseline

Q12. Additional comments

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Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.