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 1
- ☐ Spinal Muscle Atrophy (SMA) Type 2
- ☐ Spinal Muscle Atrophy (SMA) Type 3
- ☐ Spinal Muscle Atrophy (SMA) Type 4
- ☐ Other

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

Q3. Is the patient a new start to therapy?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q5. Was the onset of disease before 15 years of age?

☐ Yes ☐ No

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Q6. Was diagnosis of SMA confirmed by 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygous mutation? (Please provide documentation)

☐ Yes ☐ No

Q7. 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

Q8. Please provide baseline motor ability testing using: the Hammersmith Infant Neurological Exam (HINE), the Hammersmith Functional Motor Scale Expanded (HFMSE), or Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP INTEND)

Q9. Is Spinraza dosed in accordance with FDA labeling?

☐ Yes ☐ No

Q10. 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
☐ HFMSE: improvement of at least 3 points or maintenance of previous improvement
☐ CHOP-INTEND: Improvement or maintenance of previous improvement of at least a 4 point increase in score from pretreatment baseline

Q11. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

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Q12. Provide name and NPI of the billing entity
Q13. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)? ☐ Medical ☐ Pharmacy
Q14. Additional comments

_____ _____

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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.