HUSKY Health Program Spinraza® (nusinersen)
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information				
Member ID Number:		Member Name (Last, First):		DOS:
DOB:	Sex:	Primary Diagnosis Code:	HCPCS Code:	
Address:		City, State, Zip:		

Please indicate the type of request:
- □ Initial Request
- □ First Reauthorization Request - (Establishing Effectiveness of Therapy)
- □ Subsequent Reauthorization Requests - (Documentation of Continued Medical Necessity)

ALL Authorization Requests:
Please fill out completely for **all initial and reauthorization** requests.

1. Please indicate the patient's SMA Diagnosis:
   - □ Pre-Symptomatic SMA
   - □ Symptomatic SMA:
     - □ Type 1 □ Type 2 □ Type 3

   Note: The use of Spinraza® (nusinersen) is considered investigational in the treatment of SMA Types 0 and 4.

2. Has Spinraza® been ordered by, or in consultation with, a physician experienced in the treatment of SMA?	◯Yes	◯No
3. Is the patient dependent on permanent ventilatory support (defined as tracheostomy or non-invasive ventilator support for at least 16 hours per day for > 21 days in the absence of an acute reversible event)?	◯Yes	◯No
4. Is the patient on concurrent SMN modifying SMA therapy [e.g., Evrysdi® (risdiplam)]?	◯Yes	◯No
5. Will the Spinraza® administration follow all current FDA-approved labeling for dosing and monitoring?	◯Yes	◯No

INITIAL Authorization Requests:
Please fill out completely for all **initial authorization** requests.

1. Has the diagnosis of SMA been made by, or in consultation with, a physician with expertise in diagnosing SMA? **If yes, please specify:** Provider Name: _____ Phone Number: _____	◯Yes	◯No
2. Has genetic testing been performed and confirmed a homozygous deletion, homozygous mutation, or compound heterozygous mutations of the SMN1 gene on chromosome 5q? ***Please attach genetic testing.***	◯Yes	◯No
3. Previous treatment with gene replacement therapy [e.g., Zolgensma® (onasemnogene abeparvovec)]:		
a. Has the patient previously received gene replacement therapy for SMA?	◯Yes	◯No
b. If yes to (a), has the patient experienced a decline in clinical status?	◯Yes	◯No
4. Has a **baseline** motor exam been completed by a physician or physical therapist experienced in treating SMA?	◯Yes	◯No

5. Please indicate the motor exam used and provide the baseline score: ***Please attach motor exam results.***
   - □ Hammersmith Infant Neurological Exam, Section 2 (HINE-2)
   - □ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
   - □ Hammersmith Functional Motor Scale Expanded (HFMSE)
   - □ Revised Upper Limb Module (RULM)
   - □ Other

   If other, ***please provide test name***: _____

   Baseline Pre-Treatment Exam Score:_____ Date of Exam:_____

6. Has a description of the benefits, risks, and treatment expectations been provided to the individual, parent, or guardian?	◯Yes	◯No

FIRST Reauthorization Requests ONLY:
Please fill out completely to document response to treatment.

1. Has a re-examination motor exam been performed by a physician or physical therapist experienced in treating SMA?	◯Yes	◯No

2. Please indicate the motor exam used, post-treatment score, and change from the baseline: ***Please attach motor exam results.***
   - □ Hammersmith Infant Neurological Exam, Section 2 (HINE-2)
   - □ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
   - □ Hammersmith Functional Motor Scale Expanded (HFMSE)
   - □ Revised Upper Limb Module (RULM)
   - □ Other

   If other, ***please provide test name***: _____

   Post-Treatment Exam Score:_____ Change from Baseline Score: _____
   Date of Exam:_____

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3. Has the individual responded to the treatment by demonstrating one of the following: a. An improved motor ability in repeat motor testing? b. An achievement and maintenance of any new motor skills from pretreatment baseline when they would otherwise be unexpected to do so? c. Maintenance of all prior motor skills with no decline in functional status? **Note: If no clear response is noted *and the individual has demonstrated a decline in functional status*, a letter from the treating physician explaining why the medication should be continued, along with supporting documentation from the medical literature, must be attached to this request.**	◯ Yes ◯ Yes ◯ Yes	◯ No ◯ No ◯ No
4. Has the individual received gene replacement therapy [e.g., Zolgensma® (onasemnogene abeparvovec)] since Spinraza® therapy was initially approved? ***Please attach signed provider attestation.***	◯ Yes	◯ No
5. If the individual was prescribed Spinraza® due to clinical worsening after receiving gene replacement, is there documentation of stabilization or improvement in clinical status with Spinraza® therapy (e.g., impact on motor milestones)? ***Please attach signed provider attestation.***	◯ Yes	◯ No
6. Does documentation show that the benefits of treatments continue to outweigh the risks (i.e., continued intrathecal injections)? ***Please describe and attach signed provider attestation:***	◯ Yes	◯ No

SUBSEQUENT Reauthorizations Please fill out completely.		
1. Does documentation show that the benefits of treatments continue to outweigh the risks (i.e., continued intrathecal injections)? ***Please describe and attach signed provider attestation:***	◯ Yes	◯ No
2. Has the individual received gene replacement therapy [e.g., Zolgensma® (onasemnogene abeparvovec)] since Spinraza® therapy was originally approved? ***Please attach signed provider attestation.***	◯ Yes	◯ No
3. If the individual was prescribed Spinraza® due to clinical worsening after receiving gene replacement therapy is there documentation of stabilization or improvement in clinical status with Spinraza® therapy (e.g., impact on motor milestones)? ***Please attach signed provider attestation.***	◯ Yes	◯ No

Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	
Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	Provider Specialty:
Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner-signed order is on file. This form, and any statement on my letterhead attached hereto, has been completed by me or by my employee, and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.	
Provider Signature:	Date: