AmeriHealth Caritas New Hampshire

Spinraza® (Nusinersen)

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
Specialty:		NPI number:	
Phone #:	Fax #:		

Clinical history
1. Does the patient have a confirmed diagnosis of spinal muscular atrophy? ☐ Yes ☐ No
2. Has genetic testing been completed to demonstrate SMN1 homozygous gene deletion and mutation? ☐ Yes ☐ No
3. Has quantitative spot urine protein testing at baseline been completed? ☐ Yes ☐ No If yes to question 3, results will be required prior to each dose for continued approval. Renewal lab work date(s):
4. Has a complete blood count at baseline been completed? ☐ Yes ☐ No If yes to question 4, results will be required prior to each dose for continued approval. Renewal lab work date(s):
5. Has a baseline assessment been completed with at least one of the following? ☐ Yes ☐ No ☐ Hammersmith Functional Motor Scale Expanded (HFMSE) ☐ Hammersmith Infant Neurologic Exam (HINE) ☐ 6-minute walk test (6MWT) ☐ Upper limb module (ULM) score
For renewals (every 120 days), patient must demonstrate improvement or lack of progression in one of the above assessments? Renewal assessment results:
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.
Facility where infusion to be provided:
Medicaid provider number of facility:

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.