

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM
SPINRAZA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Spinraza® (nusinersen)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of spinal muscular atrophy (SMA) type I, II, or III?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the requesting provider a neurologist with expertise in spinal muscular atrophy?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does clinical documentation show one of the following: <ul style="list-style-type: none"> • 5q SMA homozygous gene deletion or mutation • Compound heterozygote mutation 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the member ≤15 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the member dependent on either invasive ventilation or tracheostomy?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does documentation contain a baseline platelet count?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Does documentation include at least one of the following baseline motor ability scores: <ul style="list-style-type: none"> • Hammersmith Infant Neurological Exam (HINE) • Hammersmith Functional Motor Scale Expanded (HFMSE) • Upper Limb Module Test (non-ambulatory) • Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
8. Has the member received treatment with Zolgensma®?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

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REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 7 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member meet initial authorization criteria?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member received treatment with Zolgensma®?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does documentation show platelet counts prior to each dose?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the member responded to therapy with documentation showing maintenance or improvement in motor milestones?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- M007
 Origination Date: 02/07/2019
 Reviewed/Revised Date: 11/01/2019
 Next Review Date: 11/06/2020
 Current Effective Date: 11/06/2019

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