Spinraza® (Nusinersen) Prior Authorization Form

Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (410) 333-5398
Phone: (833) 325-0105

Date: _____

Patient Information

Name: _____ DOB: _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____Weight: _____

Prescriber Information

Name: _____ NPI: _____ Specialty: ❑ Neurology

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Diagnosis

❑ Spinal Muscular Atrophy (SMA) Type ❑ I ❑ II ❑ III ❑ Other: _____

❑ Diagnosed by a neurologist with SMA expertise

Genetic tests confirm:

❑ 5q SMA homozygous gene deletion, homozygous gene mutation, or compound heterozygous mutation

❑ At least 2 copies of SMN2

Prescription Information

❑ Initial request. *Four loading doses are approved when criteria are met.*

❑ Renewal request. *Each maintenance dose must be preauthorized.*

❑ Spinraza dose: 12mg/5ml

❑ Has the patient received Spinraza before: ❑ Yes ❑ No

If yes, start date: _____ # doses received: _____ last dose date: _____ next dose date: _____

Clinical Information:

❑ Patient is not dependent on invasive ventilation or tracheostomy.

❑ Patient is not dependent on non-invasive ventilation beyond naps and sleep time use.

❑ Patient with SMA Type II or III has some functional upper extremity use.

For initial therapy, please submit following documents:

❑ Baseline motor test results. Perform the test using at least one of the following methods:

- ❑ Hammersmith Infant Neurological Exam (HINE)

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- ❑ Hammersmith Functional Motor Scale Expanded (HFMSE)
- ❑ Upper Limb Module Test (non-ambulatory)
- ❑ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)

❑ Most recent medical notes supporting clinical criteria.

For continuing therapy, please submit following documents:

❑ Repeat motor test results. The test must be performed after the last dose of Spinraza and not more than 1 month prior to the next scheduled dose.

Use the motor test method utilized at baseline motor testing unless the method is no longer appropriate. This test must support a positive response to the treatment as defined by the following:

1. HINE: ❑ Improvement or maintenance of previous improvement of at least 2 points (or max score of 4) in ability to kick (improvement in at least 2 milestones). Or,

   ❑ Improvement or maintenance of previous improvement of at least 1 point increase in motor milestones of head control, rolling, sitting, crawling, standing, or walking (consistent with improvement by at least 1 milestone). And,

   ❑ Improvement or maintenance of previous improvement in more HINE motor milestones than worsening.
2. HFMSE: ❑ Improvement or maintenance of improvement of at least a 3-point increase in score
3. ULM: ❑ Improvement or maintenance of previous improvement of at least 2-point increase in score
4. CHOP-INTEND: ❑ Improvement or maintenance of previous improvement of at least 4-point increase in score

❑ Most recent medical notes supporting clinical criteria.

Review Spinraza clinical criteria in MDH website before submitting this form

I attest that

❑ I am a neurologist experienced in treating SMA.

❑ Patient's lab/test results and clinical data will be evaluated and monitored.

❑ The requested medication is not part of a clinical trial and that the benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature _____ Date_____