peach state health plan

Nusinersen (Spinraza)

Prior Authorization Form/Prescription

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male	☐ Female

Insurance Information (*Attach copies of cards*)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone #:	Secure Fax #:	Office Contact:	

Primary Diagnosis

ICD-10 Code: _____

☐ Spinal muscular atrophy (SMA), type _____ ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Spinraza (nusinersen)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date: _____

1. Please document the following:
   a. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score ☐ Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
   b. Hammersmith Infant Neurological Examination (HINE) motor milestone score ☐ Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
      If HINE,
      i. Has patient maintained previous improvement in one or more motor milestone categories? ☐ Yes ☐ No ☐ Not applicable
      ii. Has patient improved in more motor milestone categories than worsening? ☐ Yes ☐ No ☐ Not applicable
   c. Hammersmith Functional Motor Scale Expanded (HFMSE) motor milestone score ☐ Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
   d. Revised Hammersmith Scale (RHS) score ☐ Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
   e. Upper Limb Module (ULM) score ☐ Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
   f. Revised Upper Limb Module (RULM) score ☐ Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
   g. 6-Minute Walk Test (6MWT) distance ☐ Not applicable
      Baseline distance: _____ Date tested: _____; Current distance: _____ Date tested: _____
2. Does patient require tracheostomy or invasive or noninvasive ventilation for ≥ 16 hours per day continuously for 21 days? ☐ Yes ☐ No
3. Is Spinraza prescribed concurrently with Zolgensma? ☐ Yes ☐ No

Complete this section ONLY if the patient is <u>initiating</u> therapy OR if the patient is <u>new</u> to this health plan:

4. Is therapy prescribed by or in consultation with a neurologist? ☐ Yes ☐ No
5. Does patient have 1, 2, 3, or 4 copies of the survival motor neuron 2 (SMN2) gene? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ No
6. Does genetic testing confirm any of the following? ☐ Yes ***Mark all that apply*** ☐ No
   ☐ Homozygous deletions of SMN1 gene (e.g., absence of the SMN1 gene)
   ☐ Homozygous mutation in the SMN1 gene (e.g., biallelic mutations of exon 7)
   ☐ Compound heterozygous mutation in the SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])

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7. Does patient have a history of treatment with Zolgensma? ☐ Yes ***Submit documentation & mark all that apply*** ☐ No
   ☐ Evidence of poor response to Zolgensma (e.g., sustained decrease in CHOP-INTEND score over a period of 6 months)
   ☐ Provider attestation of clinical deterioration

Complete this section ONLY for indications other than SMA:

8. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐ Yes ☐ No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐ Yes ☐ No ☐ No, patient intolerant to drug

Physician's Signature _____ **Date:** _____ ☐ DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/ EPS PA STAFF

Authorization Information

Authorization number:	**Decision Due Date:**
J-Code:	**Coverage:** ☐ State excludes ☐ COB (secondary)
Line of Business: ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare (CY2019/20 Carved out)	**Benefit:** ❑ Medical ❑ Pharmacy

Criteria:
❑ Centene Policy
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

❑ State Specific (please include policy)

Medicare only criteria for CY2019 and CY2020: Carved out to FFS (Fee for service) Medicare