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. **If between age 0-2 years**, please document one of the following:
   a. *Current* Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score: _____
   b. *Current* Hammersmith Infant Neurological Examination (HINE) motor milestone score: _____
2. **If age ≥ 2 years**, please document *current* Hammersmith Functional Motor Scale Expanded (HFMSE) motor milestone score: _____
   If this is the first renewal since turning 2 years old, please complete question 1 and provide baseline HFMSE in question 2
3. Does patient require tracheostomy or invasive or noninvasive ventilation? ☐ Yes ☐ No
   If yes, hours/day: _____; continuous tracheostomy/ventilation days: _____
4. 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:

5. Is therapy prescribed by or in consultation with a neurologist? ☐ Yes ☐ No
6. Does patient have 1, 2, 3, or 4 copies of the survival motor neuron 2 (SMN2) gene? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ No
7. 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])
8. **If between age 0-2 years**, please document one of the following:
   a. *Baseline* CHOP-INTEND score: _____
   b. *Baseline* HINE motor milestone score: _____
9. **If age ≥ 2 years**, please document *baseline* HFMSE motor milestone score: _____
10. 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

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Please continue to page 2

Complete this section ONLY for indications <u>other</u> than spinal muscular atrophy:

11. 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	**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:
❑ PART B use LCD or NCD ❑ PART D use MCPD.PA.247 Tier and Formulary Exceptions Request Criteria