HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
SPINRAZA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

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 1, 2 or 3?	☐	☐	**Please provide documentation**
2. Is the requesting provider a neurologist with expertise in spinal muscular atrophy?	☐	☐	
3. Does clinical documentation show one of the following: • 5q SMA homozygous gene deletion or mutation • Compound heterozygote mutation	☐	☐	**Please provide documentation**
4. Is the member ≤15 years of age?	☐	☐	
5. Is the member dependent on either invasive ventilation or tracheostomy?	☐	☐	
6. Does documentation contain a baseline platelet count?	☐	☐	**Please provide documentation**
7. Does documentation include at least one of the following baseline motor ability scores: • 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)	☐	☐	**Please provide documentation**
8. Has the member received treatment with Zolgensma®?	☐	☐	**Please provide documentation**
9. Does clinical documentation show trial and failure or contraindication/intolerance to Evrysdi® (risdiplam)?	☐	☐	**Please provide documentation**

10. Is member currently taking Evrysdi® (risdiplam) or are there plans to start Evrysdi® (risdiplam)?			
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 7 months?	☐	☐	
3. Does the member meet initial authorization criteria?	☐	☐	**Please provide documentation**
4. Has the member received treatment with Zolgensma®?	☐	☐	**Please provide documentation**
5. Does documentation show platelet counts prior to each dose?	☐	☐	**Please provide documentation**
6. Has the member responded to therapy with documentation showing maintenance or improvement in motor milestones?	☐	☐	**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:			

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Policy PHARM-HU-M007
Origination Date: 01/01/2022
Reviewed/Revised Date: 10/26/2022
Next Review Date: 10/26/2023
Current Effective Date: 11/01/2022