



Spinraza® (nusinersen)

(Note: Maximum Length of Approval is 8 Months)

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID# [grid]

Date of Birth (MM/DD/YYYY) [grid]

Recipient's Full Name [grid]

Prescriber's Full Name [grid]

Prescriber's NPI [grid]

Prescriber Phone Number [grid]

Prescriber Fax Number [grid]

Table with columns: MEDICATION (Spinraza), QUANTITY, DIRECTIONS

Diagnosis \_\_\_\_\_

Provider Specialty \_\_\_\_\_

Initiation of Therapy OR Continuation of Therapy

MEDICAL HISTORY table with rows for Invasive Ventilation, Non-invasive ventilation, Tracheostomy, Scoliosis, Spine Surgery

NOTE: OFFICIAL LAB REPORTS AND TESTING MUST BE SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST. FORM AND LAB DATA MUST BE COMPLETED IN FULL.

Official Genetic Testing Confirming Diagnosis: Yes No, Assessment Motor Milestone Score: Yes No, Name of Assessment: \_\_\_\_\_, Date of Assessment: \_\_\_\_\_

Platelet Count: \_\_\_\_\_, Coagulation Laboratory Testing: Yes No, Date of lab: \_\_\_\_\_

Quantitative Spot Urine Testing: Yes No, Date of lab: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REQUIRED FOR REVIEW: Copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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