

Spinraza (nusinersen)

Member and Medication Information	
* indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	<input type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information	
* indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information	
* indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at 855-828-4992 , to prevent processing delays.	

Criteria for Approval (all must be met):

- This medication is prescribed by or in consultation with a physician who specializes in spinal muscular atrophy (SMA) treatment.
- Patient has documented presymptomatic or symptomatic SMA type 1-3 confirmed with genetic testing
- Patient has not previously received Zolgensma.

Re-authorization Criteria:

- Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.
- Assessment of motor function development milestones using age-appropriate screening tools.

Spinraza Authorization: 4 doses over 58 days, then 1 dose every 4 months, up to one year

Re-authorization: Up to one (1) year

Note:

- ❖ Initiate SPINRAZA treatment with 4 loading doses; the first three loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose; a maintenance dose should be administered once every 4 months thereafter.

UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

- ❖ Use appropriate HCPCS code for billing

Coverage and Reimbursement code look up: <https://health.utah.gov/stplan/lookup/CoverageLookup.php>

HCPCS NDC Crosswalk: <https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php>

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber's Signature

Date