HUSKY Health Program Spinraza™ (nusinersen)
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994

Member Information			
Member ID #:		Member Name (Last, First):	
DOB:	Sex:	Primary Diagnosis Code:	
Street Address:		City, State, Zip:	

Please fill out completely for both initial and reauthorization requests.		
1. Is the ordering provider a neurologist experienced in the treatment of Spinal Muscular Atrophy (SMA)?	□ Yes	□ No
2. Please select the patient's diagnosis: □ SMA Type 1 □ Age of symptom onset: □ Other SMA type: If other than Type 1, treating neurologist must demonstrate why the individual should be considered for administration.		
3. Has the patient's diagnosis been confirmed by genetic tests confirming that the patient has one of the following? If yes, please check all that apply: □ Homozygous gene deletion □ Homozygous gene mutation □ Compound heterozygote mutation	□ Yes	□ No
4. Is there documentation confirming that the patient has two or more copies of SMN2 gene as determined by testing?	□ Yes	□ No
5. Is the patient on artificial ventilation? If the patient is on artificial or other mechanical respiratory support prior to Spinraza™ (nusinersen), please indicate the type, duration, and degree of ventilator support in a 24 hour period:	□ Yes	□ No
6. Has a baseline motor exam been completed by a neurologist, physiatrist, or physical therapist (specializing in SMA motor exam evaluations and supervised by a neurologist or physiatrist) experienced in treating SMA? If yes, please check all that apply and indicate score: □ Hammersmith Infant Neurological Exam (HINE) □ Hammersmith Functional Motor Scale Expanded (HFMSE) □ Upper Limb Module (ULM) Test (non-ambulatory) □ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) **Score:**	□ Yes	□ No

Please fill out completely for reauthorization requests.		
1. Has a re-examination been performed by the same examiner as the baseline exam?	□ Yes	□ No
2. If no, has a re-examination been performed by a neurologist, physiatrist, or physical therapist (specializing in SMA motor exam evaluations and supervised by a neurologist or physiatrist) experienced in treating SMA?	□ Yes	□ No
3. Please check all that apply and indicate score: □ Hammersmith Infant Neurological Exam (HINE) □ Hammersmith Functional Motor Scale Expanded (HFMSE) □ Upper Limb Module (ULM) Test (non-ambulatory) □ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) **Score:** **Additional comments regarding patient's improvement:**		

Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	

Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	

Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Provider Signature:	Date: