

## New Hampshire Medicaid Fee-for-Service Program

### Spinraza® (nusinersen) Criteria

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Approval Date: August 7, 2020

#### Criteria for Approval

1. Patient must have documentation of a confirmed diagnosis of spinal muscular atrophy (SMA); **AND**
2. Genetic testing is required to demonstrate SMN1 homozygous gene deletion or mutation; **AND**
3. Quantitative spot urine protein testing at baseline and prior to each dose; **AND**
4. Complete blood count at baseline and prior to each dose; **AND**
5. Nusinersen must be administered by a specialist with competency in intrathecal injection.
6. Provide baseline assessment using at least one of the following:
  - a. Hammersmith Functional Motor Scale Expanded (HFMSE)
  - b. Hammersmith Infant Neurologic Exam (HINE)
  - c. Six-minute walk test (6MWT)
  - d. Upper limb module (ULM) score

#### Criteria for Renewal

1. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include serious infections, life-threatening glomerulonephritis, thrombocytopenia, etc.; **AND**
2. Patient has demonstrated improvement or lack of progression in at least one of the following:
  - a. Hammersmith Functional Motor Scale Expanded (HFMSE)
  - b. Hammersmith Infant Neurologic Exam (HINE)
  - c. Six-minute walk test (6MWT)
  - d. Upper limb module (ULM) score

#### Quantity Limit:

- Initial: Four vials for the first 58 days
- Maintenance: One vial every 120 days

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### Length of Approval:

- Initial: Six months
- Renewal: One year

### Criteria for Denial

Criteria for approval not met.

### References

Available upon request.

### Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	10/24/2017
Commissioner	Approval	12/05/2017
DUR Board	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Revision	06/30/2020
Commissioner	Approval	08/07/2020