



New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Spinraza® (nusinersen)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. Does the patient have a confirmed diagnosis of spinal muscular atrophy? Yes No
2. Has genetic testing been completed to demonstrate SMN1 homozygous gene deletion and mutation? Yes No
3. Has quantitative spot urine protein testing at baseline been completed? Yes No

If yes to question 3, results will be required prior to each dose for continued approval.

Renewal lab work date(s): _____

4. Has a complete blood count at baseline been completed? Yes No

If yes to question 4, results will be required prior to each dose for continued approval.

Renewal lab work date(s): _____

5. Has a baseline assessment been completed with at least one of the following? Yes No

- Hammersmith Functional Motor Scale Expanded (HFMSSE)
- Hammersmith Infant Neurologic Exam (HINE)
- 6-minute walk test (6MWT)
- Upper limb module (ULM) score

For renewals (every 120 days), patient must demonstrate improvement or lack of progression in one of the above assessments?

Renewal assessment results: _____

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ DATE: _____

Facility where infusion to be provided: _____

Medicaid Provider Number of Facility: _____

Fax to Magellan Rx Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.
Phone: 1-866-675-7755
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-271-8194