Nusinersen (Spinraza)

Prior Authorization Form/Prescription

Date: _____ Date Medication Required: _____

Ship to: ○ Physician ○ Patient's Home ○ Other_____

Health Net

Health Net Health Plan of Oregon, Inc.
Health Net Life Insurance Company

Prior Authorization / Formulary Exception Request Fax Form

FAX TO: (800) 255-9198

Form must be fully completed to avoid a processing delay.

For status of a request, call: (888) 802-7001

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone #:	Secure Fax #:	Office Contact:	

Primary Diagnosis

ICD-10 Code: _____

☐Spinal muscular atrophy (SMA), type _____ ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Spinraza (nusinersen)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

☐**INITIAL THERAPY** ☐**CONTINUATION OF THERAPY;** Therapy start date: _____

1. Please document the following:
   a. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score ☐Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
   b. Hammersmith Infant Neurological Examination (HINE) motor milestone score ☐Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
      If HINE,
      i. Has patient maintained previous improvement in one or more motor milestone categories? ☐Yes ☐No ☐Not applicable
      ii. Has patient improved in more motor milestone categories than worsening? ☐Yes ☐No ☐Not applicable
   c. Hammersmith Functional Motor Scale Expanded (HFMSE) motor milestone score ☐Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____
   d. Revised Hammersmith Scale (RHS) score ☐Not applicable
      Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____

Please continue to page 2.

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e. Upper Limb Module (ULM) score ☐Not applicable
Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____

f. Revised Upper Limb Module (RULM) score ☐Not applicable
Baseline score: _____ Date tested: _____; Current score: _____ Date tested: _____

g. 6-Minute Walk Test (6MWT) distance ☐Not applicable
Baseline distance: _____ Date tested: _____; Current distance: _____ Date tested: _____

2. Does patient require tracheostomy or invasive or noninvasive ventilation for ≥ 16 hours per day continuously for 21 days? ☐Yes ☐No
3. Is Spinraza prescribed concurrently with Zolgensma? ☐Yes ☐No

Complete this section ONLY if the patient is initiating therapy OR if the patient is new to this health plan:

4. Is therapy prescribed by or in consultation with a neurologist? ☐Yes ☐No
5. Does patient have 1, 2, 3, or 4 copies of the survival motor neuron 2 (SMN2) gene? ☐1 ☐2 ☐3 ☐4 ☐No
   If yes,
   a. Was genetic testing results dated with the past year? ☐Yes ☐No ☐Not applicable
   b. Was genetic testing via MPLA repeated for confirmation of SMN2 gene copy number? ☐Yes ☐No ☐Not applicable

Patient Name: _____ DOB: _____

6. Does genetic testing confirm any of the following? ☐Yes ***Mark all that apply*** ☐No
   ☐Homozygous deletions of SMN1 gene (e.g., absence of the SMN1 gene)
   ☐Homozygous mutation in the SMN1 gene (e.g., biallelic mutations of exon 7)
   ☐Compound heterozygous mutation in the SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
7. Does patient have a history of treatment with Zolgensma? ☐Yes ***Submit documentation & mark all that apply*** ☐No
   ☐Evidence of poor response to Zolgensma (e.g., sustained decrease in CHOP-INTEND score over a period of 6 months)
   ☐Provider attestation of clinical deterioration

Complete this section ONLY for indications other than SMA:

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/ EPS PA STAFF

Authorization Information

Authorization number:	**Decision Due Date:**
J-Code:	**Coverage:** ☐ State excludes ☐ COB (secondary)
Line of Business: ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare (CY2019/20 Carved out)	**Benefit:** ❑ Medical ❑ Pharmacy

Criteria:
❑ Centene Policy
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

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❑ State Specific (please include policy)

Medicare only:

❑ PART B use LCD or NCD ❑ PART D use MCPD.PA.247 Tier and Formulary Exceptions Request Criteria

8. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No

If yes, submit documentation and answer the following:

a. Please list all previous therapies: _____

b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Physician's Signature _____ **Date:** _____ ☐ DAW