

Montana Healthcare Programs Prior Authorization Request Form for Spinraza® (nusinersen)

Member Name:	Date:	
Member ID:	DOB:	
Prescriber: Dr. Eliad Culcea	Prescriber Phone: (406) 315-5950 x4	Prescriber Fax: (406) 952-0446

*Please complete below information for applicable situation, **Initial** or **Renewal** of therapy:*

INITIAL COVERAGE CRITERIA (Member must meet all the following criteria):

- ☐ Member must have a diagnosis of Spinal Muscular Atrophy Type 1, 2, or 3 (SMA1, SMA2, or SMA3) confirmed by genetic testing.
- ☐ Genetic testing has confirmed chromosome 5q homozygous deletions or dysfunctional point mutations of the SMN1 gene and 2 to ≤ 4 copies of SMN2 gene.
- ☐ Member must not have permanent ventilator dependence.
- ☐ Spinraza® is prescribed by a neurologist.
- ☐ Prescriber must submit documentation of a baseline motor function milestone evaluation using at least one of the following age-appropriate screening tools: HINE-2, CHOP-INTEND, HFMSE, RULM, 6MWT
- ☐ Provider attests that the following laboratory tests will be performed at baseline and prior to each administration of Spinraza®: platelet count, coagulation test, quantitative spot urine protein test (*please attach labs for review*).
- ☐ Member has not previously received Zolgensma®, or member has previously received Zolgensma® and has experienced a worsening in clinical status.
- ☐ Member is not concurrently using Evrysdi™.

Quantity Limitations: Max of 12mg/dose intrathecally, as follows: The first 3 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.

Initial authorization will be issued for 6 months (total of first 4 loading doses and 1 maintenance dose).

RENEWAL COVERAGE CRITERIA (Member must meet all the following criteria):

- ☐ Member has been adherent to Spinraza®.
- ☐ Member has experienced a positive clinical response, as demonstrated by improvement or maintenance of motor skills as compared to pre-treatment baseline using at least one of the following age appropriate screening tools: HINE-2, CHOP-INTEND, HFMSE, RULM, 6MWT (*please attach screening test*)

Baseline screening test: _____	Score: _____	Date: _____
Current screening test: _____	Score: _____	Date: _____

**If current score not improved from baseline, please indicate how member has experienced a positive clinical response:*

- ☐ Provider attests that the following laboratory tests are being performed prior to each administration of Spinraza®: platelet count, coagulation test, and quantitative spot urine test (*please attach labs for review*)
- ☐ Member has not received Zolgensma®, or member has previously received Zolgensma® and has experienced a worsening in clinical status.
- ☐ Member is not concurrently using Evrysdi™.

Reauthorization will be issued for 12 months.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.