aetna™

LOUISIANA MEDICAID
NUSINERSEN (SPINRAZA®) CLINICAL AUTHORIZATION FORM

SECTION I — SUBMISSION

Submitted to:	Phone:	Fax:	Date:
Aetna Better Health® of Louisiana	**1-855-242-0802**	**1-844-699-2889**	

SECTION II — PRESCRIBER INFORMATION

Last Name, First Name MI:		NPI# or Plan Provider #:	Specialty:	
Address:		City:	State:	Zip Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION III – PATIENT INFORMATION

Last Name, First Name MI:	DOB:	Phone:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Plan Name (if different from Section I):	Member or Medicaid ID #:	Plan Provider ID:	

Is the patient currently a hospital inpatient getting ready for discharge? ____ Yes ____ No Date of Discharge:_____
EPSDT Support Coordinator contact information, if applicable: _____

SECTION IV — PRESCRIPTION DRUG INFORMATION

Requested Drug Name: Nusinersen (Spinraza®)

Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:	Expected Therapy Duration/Start Date:

To the best of your knowledge this medication is:
_____New therapy/Initial request
_____Continuation of therapy/Reauthorization request
If continuation of therapy, date of initiation: _____
Has this medication been prescribed by, or in consultation with, a physician who specializes in the treatment of spinal muscular atrophy? _____ Yes _____ No
Has this recipient previously been treated with onasemnogene abeparvovec-xioi (Zolgensma®)? _____ Yes _____ No
Onasemnogene abeparvovec-xioi treatment date _____ and result _____
Will the patient receive the drug in the physician's office? ____Yes ____No
If no, list name and NPI of servicing provider/facility: _____
If yes, please complete the following:
HCPCS/CPT-4 Code:_____NDC#:_____Dose Per Administration:_____
Other Codes:_____

SECTION V — PATIENT CLINICAL INFORMATION

Does the patient have a diagnosis of spinal muscular atrophy (SMA)? ____Yes ____No

If yes, date diagnosed: _____

If yes, what type of SMA does the patient have? (Select one below.)

☐ Type I (infantile onset or Werdnig-Hoffman disease [ICD-10-CM G12.0], symptoms are present at birth or by 6 months of age, unable to sit without assistance)

☐	Type II (intermediate SMA [ICD-10-CM G12.1], symptoms develop between 6 months and 12 months of age, able to sit unassisted but unable to stand or walk independently)
☐	Type III (mild SMA or Kugelberg-Welander disease (ICD-10-CM G12.1), usually diagnosed between early childhood and adolescence, able to stand and walk independently but may lose this ability later in life)

Has the diagnosis been confirmed by genetic testing? ____Yes _____No

If yes, did the testing confirm 5q SMA homozygous gene mutation, homozygous gene deletion, or compound heterozygote?
____Yes __✔__No

Does the patient require ventilator support for 16 or more hours per day? ____Yes _____No
If yes, date of initiation: _____

Motor Milestone Test*	Score	Measurement Date	Specialty of Provider Administering Test
For recipients ≤ 2 years of age: Hammersmith Infant Neurological Examination Section 2 (HINE-2)			
For ambulatory recipients ≥3 years of age: Hammersmith Functional Motor Scale Expanded (HFMSE)			
For non-ambulatory recipients >3 years of age: Revised Upper Limb Module (RULM)			

**Results of most recent motor milestone test MUST be included for both initial and continuation / reauthorization requests.*

Name of Pertinent Laboratory Test(s)	Date of Test	Results

SECTION VI — FOR CONTINUATION OF THERAPY / REAUTHORIZATION REQUESTS ONLY

From baseline motor milestone score to most recent motor milestone score:
Has the patient received a clinical benefit from Spinraza® therapy as evidenced by improvement or maintenance of motor skills or ability to sit, crawl, stand or walk, or new motor milestones? ____Yes _____No

When considering all categories of motor milestones, are the number of categories that show improvement greater than the number that shows worsening? ____Yes _____No

SECTION VII — ADDITIONAL CLINICAL INFORMATION

PHARMACY INFORMATION (OPTIONAL)

Pharmacy Name:	Phone:

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber:_____ Date:_____