South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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PIERRE, SD 57501-22941

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SPINRAZA PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA		
☐	**Medical records to support use of product are submitted**	
Initial Therapy (check one)	**Yes** ☐	**No** ☐
☐	Therapy is prescribed by, or in consultation with, a neurologist with expertise in the treatment of SMA	
☐	Individual has a diagnosis of spinal muscular atrophy type I, II, or III by, or in consultation with, a neurologist with expertise in the diagnosis of SMA	
☐	Submission of medical records (e.g., chart notes, laboratory values) confirms the mutation or deletion of genes in chromosome 5q resulting in **one** of the following: ☐ Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) ☐ Compound heterozygous mutation (e.g., deletion of SMN1 exon 7[allele 1] and mutation of SMN1 [allele 2])	
☐	Individual has ≤3 copies of SMN2 gene	
☐	Individual is not dependent on **either** of the following: • Invasive ventilation or tracheostomy • Use of non-invasive ventilation beyond use for naps and nighttime sleep	
☐	Documentation is submitted indicating the individual's baseline Hammersmith Functional Motor Scale Expanded (HFMSE) exam by a board certified neurologist. If the HFMSE is not appropriate for the patient, provide the test used to establish baseline motor ability	
☐	Therapy is not prescribed concurrently with Evrysdi	
☐	Individual meets **one** of the following in regards to previous gene replacement therapy for the treatment of SMA: ☐ Individual has not previously received gene replacement therapy for the treatment of SMA ☐ Individual has a history of receiving gene replacement therapy and has experienced a declination in clinical status since receipt	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Individual continues to meet initial criteria	
☐	Submission of medical records (e.g., chart notes, laboratory values) with the most recent results (< 1 month prior to request) documenting a positive clinical response from pretreatment baseline status to Spinraza therapy as demonstrated by the initial test used to establish baseline motor ability unless that test is no longer appropriate for the patient	
☐	Improvement standards must meet **one** of the following: ☐ Maintenance or improvement in score from pretreatment baseline ☐ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form must be signed by a provider		
☐	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		**Specialty:**
Signature:		