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## SPINRAZA PRIOR AUTHORIZATION REQUEST FORM

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

Date:		
<b>RECEIPIENT INFORMATION</b>		
Medicaid ID:	Date of Birth:	Sex:    M        F
Last Name:		First Name:
<b>GENERAL INFORMATION</b>		
First Date of Service:	Last Date of Service:	
Primary Diagnosis Code:	HCPC Code:	
Drug Name:	Dose & Frequency:	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
<b>POINT OF CONTACT</b>		
Name and Title:		
Email:	Phone:	Fax:
<small><i>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.</i></small>		
<b>REFERRING PROVIDER INFORMATION</b>		
Name:		
NPI #:	Taxonomy:	
Phone:	Fax:	
<b>SERVICING PROVIDER INFORMATION</b>		
Name:		
Address:		
NPI #:	Taxonomy:	
Phone:	Fax:	

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
Therapy is prescribed by a neurologist with expertise in the treatment of SMA		
Individual has an SMA diagnosis with submitted documentation (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)</li> <li>• Compound heterozygous mutation of SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])</li> </ul>		
Individual has ≤3 copies of SMN2 gene		
Individual is not dependent on <b>either</b> of the following: <ul style="list-style-type: none"> <li>• Invasive ventilation or tracheostomy</li> <li>• Use of non-invasive ventilation beyond use for naps and nighttime sleep</li> </ul>		
Baseline functional status is documented by <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorder score (CHOP INTEND)</li> <li>• Hammersmith Infant Neurological Exam (HINE)</li> <li>• Hammersmith Functional Motor Scale Expanded (HFMSSE)</li> </ul>		
Therapy is not prescribed concurrently with Evrysdi or other SMN modifying therapies		
Individual has not previously received gene replacement therapy for the treatment of SMA – request for coverage post gene replacement therapy will be determined on a case by case basis		
<b>Continuation of Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
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 <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Maintenance or improvement in score from pretreatment baseline</li> <li>• Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so</li> </ul>		
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
This form <u>must be</u> signed by a provider		
I certify that the information given in this form is a true and accurate medical indication for the required product		
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		