New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Spinraza® (nusinersen)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. **Does the patient have a confirmed diagnosis of spinal muscular atrophy?** ☐ Yes ☐ No
2. **Has genetic testing been completed to demonstrate SMN1 homozygous gene deletion and mutation?** ☐ Yes ☐ No
3. **Has quantitative spot urine protein testing at baseline been completed?** ☐ Yes ☐ No

   If yes to question 3, results will be required prior to each dose for continued approval.

   Renewal lab work date(s): ____________________

4. **Has a complete blood count at baseline been completed?** ☐ Yes ☐ No

   If yes to question 4, results will be required prior to each dose for continued approval.

   Renewal lab work date(s): ____________________

5. **Has the patient ever received a dose of Zolgensma®?** ☐ Yes ☐ No
6. **Will the patient receive concurrent therapy with Evrysdi™ (risdiplam)?** ☐ Yes ☐ No
7. **Has a baseline assessment been completed with at least one of the following?** ☐ Yes ☐ No
   - Hammersmith Functional Motor Scale Expanded (HFMSE)
   - Hammersmith Infant Neurologic Exam (HINE)
   - 6-minute walk test (6MWT)
   - Upper limb module (ULM) score

   For renewals, patient must demonstrate improvement or lack of progression in one of the above assessments?

   Renewal assessment results: ____________________

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

____

Fax to Magellan Rx Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.
Phone: 1-866-675-7755
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-271-8194

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Effective Date: **03/01/2022**

MagellanRx MANAGEMENT℠

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I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: ____ **DATE**: ______________________________

Facility where infusion to be provided: ____

Medicaid Provider Number of Facility: ____

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