OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Spinraza® (Nusinersen) Prior Authorization Form

SoonerSelect | aetna

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

❑ ***Physician billing (HCPCS code:_____)*** ❑ ***Pharmacy billing (NDC:_____)***

Start Date (or date of next dose):_____ Dose:_____ Regimen:_____

Billing Provider Information

NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Name of outpatient hospital facility where Spinraza® will be delivered to and administered at:

_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Has the member previously been treated with Spinraza® (nusinersen)? Yes☐ No☐
   A. If member has previously received nusinersen, please provide dates of previous doses:_____
2. What is the member's diagnosis?
   ❑ Spinal Muscular Atrophy (SMA)
   A. What type of SMA does the member have (0-4)?_____
   B. Does member currently have symptoms consistent with SMA? Yes☐ No☐
   C. Has the diagnosis been confirmed by molecular genetic testing? Yes☐ No☐
   D. Does member have biallelic pathogenic variants in the survival motor neuron gene 1 (*SMN1*)? Yes☐ No☐
   ❑ Other:_____
3. Is member currently dependent on permanent ventilation? Yes☐ No☐
   A. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support:_____
4. Is Spinraza® being prescribed by a neurologist, specialist with expertise in the treatment of SMA, or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA? Yes☐ No☐
5. Has member previously received treatment with Zolgensma® (onasemnogene abeparvovec-xioi)? Yes☐ No☐
6. Has the member previously been treated with Evrysdi™ (risdiplam)? Yes☐ No☐
   A. If yes, will the member discontinue treatment with Evrysdi™ upon approval of Spinraza®? Yes☐ No☐
7. Has platelet count, coagulation laboratory testing, and quantitative spot urine protein testing been obtained? Yes☐ No☐
   A. If yes, are levels acceptable to the prescriber? Yes☐ No☐
8. Does prescriber agree to do a platelet count, coagulation testing, and quantitative spot urine protein testing prior to each dose? Yes☐ No☐
9. Will Spinraza® be administered in a health care facility by a specialist experienced in performing lumbar punctures? Yes☐ No☐
10. Has a baseline assessment been performed and documented using at least 1 of the following exams as functionally appropriate: Hammersmith Infant Neurological Exam (HINE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Upper Limb Module (ULM) Test, or Hammersmith Functional Motor Scale Expanded (HFMSE)? Yes☐ No☐
    A. If yes, please indicate the exam performed:_____
    B. Please provide member's baseline score to exam listed above:_____

For Continued Authorization:

1. Has the member previously been approved through the SoonerCare prior authorization process? Yes☐ No☐
   A. If no, please complete the initial authorization section above.
2. Is member responding to the medication as demonstrated by a clinically significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment? Yes☐ No☐
3. Please indicate exam used to perform assessment: _____
   A. Please provide member's baseline score to exam listed above:_____
   B. Please provide member's current score to exam listed above:_____
4. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support: _____

Prescriber Signature: _____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.