NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Nebraska Medicaid Fee-For-Service Pharmacy Benefit

# PRIOR AUTHORIZATION – Nusinersen (Spinraza)

If the prior authorization request is approved, payment is still subject to all general requirements including current member eligibility, other insurance, and other program restrictions.

***Member information**
*Last name _____* First name _____ MI _____

*Medicaid Member ID: _____ *Date of birth: _____
**Prescriber Information**
Last name* _____ First name* _____ MI _____
NPI* _____ NE Medicaid Provider ID _____
Address _____ City _____ State _____ Zip _____
E-mail address _____
Telephone No.* _____ Fax No.* _____
Initial Therapy Authorization: Yes ____ No ___

1. Diagnosis of spinal muscular atrophy (SMA) by, or in consultation with, a neurologist with expertise in the diagnosis of SMA: Yes ___ No ___
2. Spinraza is prescribed by or in consultation with a neurologist with expertise in the treatment of SMA: Yes ___ No ___
3. Submission of medical records (e.g., chart notes, laboratory values) confirming 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): Yes ___ No___
   OR
   Compound heterozygous mutation (e.g., deletion of SMN1 exon 7[allele 1] and mutation of SMN1 [allele 2]) Yes ___ No___
4. Patient is not dependent on either of the following as result of advanced SMA:
   Ventilation dependent or has a tracheostomy? Yes ____ No ____
   Requires the use of non-invasive ventilation beyond use for naps and nighttime sleep? Yes___ No___
5. Submission of medical records (e.g., chart notes, laboratory values) of the baseline exam of at least one of the following exams (based on patient age and motor ability) to establish baseline motor ability:

Baseline assessments:
Hammersmith Infant Neurological Exam Part 2 (HINE-2) (infant to early childhood) Score _____
Hammersmith Functional Motor Scale Expanded (HFMSE) Score _____
Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) Score _____
Upper Limb Module (ULM) Test (Non ambulatory) Yes ___ No___
Previously tried therapies Yes ___ No ___

6. Is the patient receiving concomitant chronic survival motor neuron (SMN) modifying therapy? Yes __ No___

Initial authorization will be for no more than 4 loading doses.

## Continuation of Therapy: (√) Yes ___

1. Diagnosis of spinal muscular atrophy (SMA) by, or in consultation with a neurologist with expertise in the diagnosis of SMA. Yes ___ No ___
2. Spinraza is prescribed by or in consultation with a neurologist with expertise in the treatment of SMA:Yes ___ No ___
3. Patient is not dependent on either of the following as a result of advanced SMA:
   Ventilation dependent or has a tracheostomy? Yes ____ No ____
   Requires the use of non-invasive ventilation beyond use for naps and nighttime sleep? Yes___No___
4. Is the patient is receiving concomitant chronic survival motor neuron (SMN) modifying therapy? Yes___ No___

5. Submission of medical records (e.g., chart notes, laboratory values) with the most recent results (≤ 3 months prior to the request) to establish clinically significant improvement and a positive clinical response from pretreatment baseline status, or maintenance of function, to Spinraza therapy using the same assessment(s) used for the baseline exam? Yes ___ No ___

Re-authorization will be for no more than 3 maintenance doses (12 months)

Note:
Spinraza is not proven or medically necessary for:
Spinal muscular atrophy without chromosome 5q mutations or deletions
Concomitant treatment of SMA in patients who have previously received gene replacement therapy
Concomitant treatment of SMA in patients receiving chronic survival motor neuron (SMN) modifying therapy

All other uses of nusinersen (Spinraza) are considered investigational and not medically necessary.

Any additional physician comments:

_____

**Ordering Physician's Signature_____** Date _____

Submit this form and medical records to Nebraska Medicaid Pharmacy Program Specialist by: **FAX: (402) 471-9103 ;; or Mail at P.O. Box 95026, Lincoln, NE 68509**

**DO NOT WRITE BELOW THIS LINE-MEDICAID USE ONLY:**

Initial Therapy

Approval for Spinraza 4 loading doses and first maintenance dose from _____to _____.

Continuation of Therapy: 12 months Treatment should be evaluated; initial treatment with no improvement may not be covered by Medicaid.

_____ Approval for Maintenance Therapy, _____ doses for ____ months from to _____.
_____ Denied/ Rationale _____

_____

DHHS Signature Title Date

_____

Original date SPINRAZA 12/1/2018
Revised date April 2023

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