Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® 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 www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Spinraza
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:
Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	
Dispensing Pharmacy Information			
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:	

Requested Medication Information				
Are there any contraindications to formulary medications? (If yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy

Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): Yes No	What medication(s) have been tried and failed for this diagnosis? (Please specify):
What is the diagnosis ICD-10 Code?	Diagnosis:
Directions for Use:	Strength: / Dosage Form: / Quantity: / Day Supply: / Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: ______________________________

Clinical Information – Initial Request					
Was diagnosis confirmed by genetic testing?	☐ Yes	☐ No	Was documentation presented showing member has Type I, Type II, or Type III Spinal Muscular Atrophy?	☐ Yes	☐ No
Is documentation presented showing member is confirmed to have at least 2 copies of Survival Motor Neuron-2 gene?				☐ Yes	☐ No

Genetic testing confirms presence of one of the following chromosome 5q mutations or deletions:	☐ Homozygous deletions of Survival Motor Neuron-1 gene	☐ Homozygous mutation in Survival Motor Neuron-1 gene	☐ Compound heterozygous mutation in Survival Motor Neuron-1 gene

Is member dependent on any of the following (check one):	☐ Invasive ventilation for more than 16 hours per day, or tracheostomy ☐ Non-invasive ventilation for at least 12 hours per day

Was baseline motor milestone score obtained using one of the following assessments (check one):	☐ Hammersmith Functional Motor Scale Expanded	☐ Hammersmith Infant Neurologic Exam Part 2	☐ Revised Upper Limb Module test	☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders	☐ Six-minute walk test

Were the following baseline labs presented to rule out coagulation abnormalities and thrombocytopenia?	Platelet count	Prothrombin time (PT)	activated partial thromboplastin time (aPTT)	
Was a quantitative spot urine protein test completed at baseline to rule out renal toxicity presented?			☐ Yes	☐ No

Clinical Information – Renewal

ALL the following laboratory tests were completed showing improvement from pretreatment baseline status?	☐ Platelet count	☐ Prothrombin time	☐ Activated partial thromboplastin time	☐ Quantitative spot urine protein test
A response to therapy was demonstrated by one of the following:	☐ Maintained or improved motor milestone score using same exam as performed at baseline		☐ Achieved and maintained any new motor milestones, when otherwise would be unexpected to do so, using same exam as performed at baseline	

Exams (check that apply)		
☐ Hammersmith Infant Neurologic Exam Part 2	☐ There was an improvement, or maintenance of previous improvement, of at least a 2-point increase in ability to kick	☐ There was an improvement, or maintenance of previous improvement, of at least a 1-point increase, in any other milestone (for example, head control, rolling, sitting, crawling), excluding voluntary grasp
☐ Hammersmith Functional Motor Scale Expanded	☐ There was an improvement, or maintenance of previous improvement, of at least a 3-point increase in score from baseline	
☐ Revised Upper Limb Module	☐ There was an improvement, or maintenance of previous improvement, of at least a 2-point increase in score from baseline	
☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders	☐ There was an Improvement, or maintenance of previous improvement, of at least a 4-point increase in score from baseline	
☐ 6-Minute Walk Test	☐ Maintained, or improved score from baseline	

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: ______________________________ **Date:** ______________

<u>Please note: Incomplete forms or forms without the chart notes will be returned</u>

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.