



Fax completed prior authorization request form to 855-247-3677 (Integrated population) 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/rbha-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:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy	
(If yes, please specify):					
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					
<input type="checkbox"/> Standard – (24 hours)	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was documentation presented showing member has Type I, Type II, or Type III Spinal Muscular Atrophy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is documentation presented showing member is confirmed to have at least 2 copies of Survival Motor Neuron-2 gene?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Genetic testing confirms presence of one of the following chromosome 5q mutations or deletions:	<input type="checkbox"/> Homozygous deletions of Survival Motor Neuron-1 gene	<input type="checkbox"/> Homozygous mutation in Survival Motor Neuron-1 gene		<input type="checkbox"/> Compound heterozygous mutation in Survival Motor Neuron-1 gene	
Is member dependent on any of the following (check one):	<input type="checkbox"/> Invasive ventilation for more than 16 hours per day, or tracheostomy				
	<input type="checkbox"/> Non-invasive ventilation for at least 12 hours per day				
Was baseline motor milestone score obtained using one of the following assessments (check one):	<input type="checkbox"/> Hammersmith Functional Motor Scale Expanded	<input type="checkbox"/> Hammersmith Infant Neurologic Exam Part 2	<input type="checkbox"/> Revised Upper Limb Module test	<input type="checkbox"/> Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders	<input type="checkbox"/> Six-minute walk test

Were the following baseline labs presented to rule out coagulation abnormalities and thrombocytopenia?	Platelet count <input type="checkbox"/>	Prothrombin time (PT) <input type="checkbox"/>	activated partial <input type="checkbox"/> thromboplastin time (aPTT)
Was a quantitative spot urine protein test completed at baseline to rule out renal toxicity presented?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Clinical Information – Renewal			
ALL the following laboratory tests were completed showing improvement from pretreatment baseline status?	<input type="checkbox"/> Platelet count	<input type="checkbox"/> Prothrombin time	<input type="checkbox"/> Activated partial thromboplastin time
			<input type="checkbox"/> Quantitative spot urine protein test
A response to therapy was demonstrated by one of the following:	<input type="checkbox"/> Maintained or improved motor milestone score using same exam as performed at baseline	<input type="checkbox"/> 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)			
<input type="checkbox"/> Hammersmith Infant Neurologic Exam Part 2	<input type="checkbox"/> There was an improvement, or maintenance of previous improvement, of at least a 2-point increase in ability to kick	<input type="checkbox"/> 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	
<input type="checkbox"/> Hammersmith Functional Motor Scale Expanded	<input type="checkbox"/> There was an improvement, or maintenance of previous improvement, of at least a 3-point increase in score from baseline		
<input type="checkbox"/> Revised Upper Limb Module	<input type="checkbox"/> There was an improvement, or maintenance of previous improvement, of at least a 2-point increase in score from baseline		
<input type="checkbox"/> Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders	<input type="checkbox"/> There was an Improvement, or maintenance of previous improvement, of at least a 4-point increase in score from baseline		
<input type="checkbox"/> 6-Minute Walk Test	<input type="checkbox"/> 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: _____

Please note: Incomplete forms or forms without the chart notes will be returned

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 800-564-5465 to check the status of a request