NUSINERSEN (SPINRAZA) REQUEST FORM
OHIO DEPARTMENT OF MEDICAID

- ✓ Copies of all clinical documentation supporting the information below, along with the Spinraza Request Form, must be attached and submitted at the time of the request.

- ✓ Requests and supporting documents must be submitted to Ohio Medicaid via the MITS online portal.

Prior Authorization Information (Medicaid Recipient)

Last name _____ First name _____

Medicaid ID _____ D.O.B _____

Dates of Service being requested _____ to _____

Service Type/ Code_____ Number of Units _____

Provider Information

Name of Ordering Provider _____

NPI _____

Contact name (print) _____Phone _____

Signature of person completing form _____

Date _____

Provider Information

PROVIDER INFORMATION

Was SMA ***diagnosed*** by a neurologist experienced in the treatment of SMA? Yes ☐ No ☐

- ✓ If **Yes**, name of neurologist _____
- ✓ If **No**, name and specialty of diagnosing physician _____

_____

Is Spinraza being ***prescribed*** by a neurologist experienced in the treatment of SSMA?

☐ Yes No ☐

- ✓ If **Yes**, name of prescriber _____.
- ✓ If **No**, name and specialty of prescribing physician _____.

Will Spinraza be administered in a healthcare facility by a specialist experienced in performing lumbar punctures? Yes ☐ No ☐

Name of facility _____

Has the member received Zolgensma? Yes No If yes, date administered _____

Member Clinical Information (Requested by ODM)

CLINICAL INFORMATION

Current Age _____Gender_____ Ethnicity _____

SMA clinical subtype _____

Please indicate SMN1 mutation **AND** number of SMN2 gene copies:

_____

Age at diagnosis of SMA _____

Age at onset of SMA symptoms, if different than time of diagnosis _____

Were the SMA symptoms documented by a neurologist using a motor exam? Yes ☐ No ☐

Which of the following motor exam(s) were used for the Member's ***baseline*** exam?

- ✓ Children < 2 years old: Hammersmith Infant Neurological Examination Section 2 (HINE-2): Yes No N/A
- ✓ Children > 3 years old and *ambulatory* Hammersmith Functional Motor Scale-Expanded (HFMSE): Yes No N/A
- ✓ Children' > 3 years old and *non-ambulatory* Upper Limb Module Test (ULM]: Yes No N/A

Date of ***baseline*** motor exam(s) _____

Summary of results of the ***baseline*** motor exam(s) _____

_____

_____

Which of the following motor exam(s) were used for the Member's most recent exam:

- ✓ Children < 2 years old: Hammersmith Infant Neurological Examination Section 2 (HINE-2): Yes No N/A
- ✓ Children > 3 years old and ambulatory: Hammersmith Functional Motor Scale-Expanded (HFMSE): Yes No N/A
- ✓ Children' > 3 years old and non-ambulatory: Upper Limb Module Test (ULM]: Yes No N/A

Date of ***most recent*** motor exam(s) _____

Summary of results of the ***most recent*** motor exam(s)

_____

_____

Was the ***most recent*** motor exam(s) performed by the same provider who performed the baseline exam? Yes No

Does the Member require permanent ventilation? Yes No

- ✓ If **Yes**, describe type of ventilation required: _____.
- ✓ If **Yes,** number of hours of permanent ventilation support required every 24hours including naps:_____.

Does the Member require respiratory support such as noninvasive or assisted ventilation? Yes No

- ✓ If **Yes**, describe type of respiratory support required: _____.
- ✓ If **Yes,** number of hours of respiratory support required every 24 hours including naps _____

Does the Member have stable ***baseline*** labs including, but not limited to, a PT, PTT, platelets, and quantitative urine protein testing? Yes No

Will the Member have labs drawn and monitored prior to each subsequent Spinraza dose? Yes No

Has the Member ***previously*** been treated with Spinraza? Yes No

If **Yes**, indicate the following:

- ✓ Number of Spinraza doses received _____
- ✓ Date(s) of previous Spinraza treatments:

  _____
- ✓ Did Member receive any previous Spinraza doses as part of an SMA clinical trial? Yes No
- ✓ If **Yes,** how many Spinraza doses were received as part of an SMA clinical trial _____
- ✓ Please list all adverse events Member experienced following each dose:

  _____

  _____
- ✓ Has the Member shown a demonstrated response to Spinraza treatment by showing a ***significant clinical improvement*** documented using quantitative scores using the same motor function test(s) used prior to initiating Spinraza treatment? Yes No
- ✓ Was the improvement of SMA related symptoms compared to the baseline assessment and was motor function measured against the degenerative effects of SMA? Yes No
- ✓ Did a provider other than the one who initially performed the motor exam complete any follow-up exam(s)? Yes No
- ✓ Did the Member's clinical improvement include, at a minimum, the following?
  - ➢ At least a two (2) point increase in ability to kick or a one (1) point increase in head control, rolling, sitting, crawling, standing, or walking in HINE-2? Yes No N/A
  - ➢ At least a three (3) point increase in HFMSE? Yes No N/A
  - ➢ At least a two (2) point increase in ULM? Yes No N/A
- ✓ Has the Member remained free of *permanent* ventilation (16 hours or greater per 24 hours) since onset of Spinraza treatment? Yes No
- ✓ Has the Member's required any additional respiratory support since the onset of Spinraza treatment? Yes No
- ✓ Describe *all* changes to the Member's respiratory status since the onset of Spinraza treatment:

  _____

  _____

  _____

Please include additional pertinent clinical information below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____