John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PRIOR AUTHORIZATION REQUEST COVERSHEET

Please check the member's appropriate health plan listed below:

Retail Pharmacy Requests

☐ **Magellan Medicaid Administration, LLC**
For Aetna Better Health of Louisiana, AmeriHealth Caritas Louisiana, Healthy Blue, Humana, LA Healthcare Connections, United Healthcare
Phone: 1-800-424-1664 / Fax: 1-800-424-7402

☐ **Fee-for-Service (FFS) Louisiana Legacy Medicaid**
Phone: 1-866-730-4357 / Fax: 1-866-797-2329 / www.lamedicaid.com

Requests for Medications Through Medical Benefit

☐ **Aetna Better Health of Louisiana** – Medical Benefit – Physician Administered Drugs
Phone: 855-242-0802 / Fax: 844-227-9205 / TTY: 855-242-0802, 711

☐ **AmeriHealth Caritas Louisiana**
Phone: 1-800-684-5502 / Fax: 1-855-452-9131 / www.amerihealthcaritasla.com/pharmacy/priorauth.aspx

☐ **Healthy Blue** – Medical Injectables
1-844-521-6942 (M–F 7 a.m.–7 p.m., Sat. 9 a.m.–1 p.m. CT) / Fax: 844-487-9291
CenterX®: Submit through EPIC EMR

☐ **Humana** – Professionally Administered Drugs
Availity.com (registration required)
Phone: 1-866-461-7273 (M–F 7 a.m.–10 p.m. CT) / Fax: 1-888-447-3430 / (request form at Humana.com/medPA)

☐ **LA Healthcare Connections** – Physician Administered Medication (Buy and Bill)
Phone: 1-866-595-8133 / Fax: 1-866-925-3006

☐ **United Healthcare** – Medical Benefit
Phone: 1-888-397-8129 / Fax: 877-271-6290 / www.UHCprovider.com

Print Reset

Magellan Medicaid Administration

Louisiana Medicaid

nusinersen (Spinraza®) Clinical Authorization Form

Fax this form to 1-800-424-7402

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Incomplete forms will not be approved. Information contained in this form is Protected Health Information under HIPAA.

SECTION 1: SUBMISSION

Submitted to: _____

Receiver Phone: _____ Receiver Fax: _____ Date: _____

SECTION 2: PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____ Middle Initial: _____

Prescriber NPI: _____ Plan Provider #: _____ Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Office Contact Name: _____ Contact Phone: _____

SECTION 3: PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____ Middle Initial: _____

Date of Birth: _____ Patient Phone: _____

Sex: ☐ Male ☐ Female ☐ Other ☐ Unknown

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Plan Name (if different from Section 1): _____

Member #: _____ Medicaid #: _____

Plan Provider ID: _____ CCN #: _____

1. Is the patient currently a hospital inpatient getting ready for discharge?

   ☐ Yes ☐ No Date of Discharge: _____

EPSDT Support Coordinator Contact Information (if applicable):

EPSDT Support Coordinator First Name: _____

EPSDT Support Coordinator Last Name: _____

EPSDT Support Coordinator Phone: _____

Patient's Name: _____

SECTION 4: PRESCRIPTION DRUG INFORMATION

Drug Name: nusinersen (Spinraza®) Drug Strength: _____

Dosage Form: _____ Route of Admin: _____

Quantity: _____ Day Supply: _____

Directions For Use: _____

Expected Therapy Duration: _____ Start Date: _____

2. To the best of your knowledge, this medication is the following:
   ☐ New Therapy/Initial Request ☐ Continuation of Therapy/Reauthorization Request

   If Continuation of Therapy, Date of Initiation: _____

3. Has this medication been prescribed by, or in consultation with, a physician who specializes in the treatment of spinal muscular atrophy?
   ☐ Yes ☐ No

4. Has this recipient previously been treated with onasemnogene abeparvovec-xioi (Zolgensma®)?
   ☐ Yes ☐ No

   Treatment Date onasemnogene abeparvovec-xioi: _____

   Result: _____

5. Will the patient receive the drug in the physician's office?
   ☐ Yes ☐ No

   If **No**, list name and NPI of servicing provider/facility:

   Servicing Provider/Facility Name: _____

   Servicing Provider/Facility NPI: _____

   If **Yes**, please complete the following:

   HCPCS/CPT-4 Code: _____ NDC #: _____

   Dose Per Administration: _____ Other Codes: _____

SECTION 5: PATIENT CLINICAL INFORMATION

6. Does the patient have a diagnosis of spinal muscular atrophy (SMA)?
   ☐ Yes ☐ No

   If **Yes**, Date Diagnosed: _____

   If **Yes**, what type of SMA does the patient have? (Select one below.)

   ☐ Type I (infantile onset or Werdnig-Hoffman disease [ICD-10-CM G12.0], symptoms are present at birth or by 6 months of age, unable to sit without assistance)

   ☐ Type II (intermediate SMA [ICD-10-CM G12.1], symptoms develop between 6 months and 12 months of age, able to sit unassisted but unable to stand or walk independently)

   ☐ Type III (mild SMA or Kugelberg-Welander disease (ICD-10-CM G12.1), usually diagnosed between early childhood and adolescence, able to stand and walk independently but may lose this ability later in life)

Patient's Name: _____

7. Has the diagnosis been confirmed by genetic testing?†

   ☐ Yes ☐ No

   If **Yes**, did the testing confirm 5q SMA homozygous gene mutation, homozygous gene deletion, or compound heterozygote?†

   ☐ Yes ☐ No

   † **Genetic testing information** *must* be documented below.

   Date of Test: _____

   Results of Genetic Testing: _____

   Date of Test: _____

   Results of Genetic Testing: _____

8. Does the patient require ventilator support for 16 or more hours per day?

   ☐ Yes ☐ No

   If **Yes**, Date of Initiation: _____

9. Motor Milestone Test*

   For Recipients ≤ 2 years of age:

   Hammersmith Infant Neurological Examination Section 2 (HINE-2)

   Score: _____ Measurement Date: _____

   Specialty of Provider Administering Test: _____

   For Ambulatory Recipients ≥ 3 years of age:

   Hammersmith Functional Motor Scale Expanded (HFMSE)

   Score: _____ Measurement Date: _____

   Specialty of Provider Administering Test: _____

   For Non-Ambulatory Recipients > 3 years of age:

   Revised Upper Limb Module (RULM)

   Score: _____ Measurement Date: _____

   Specialty of Provider Administering Test: _____

   Results of most recent motor milestone test* **must be included for *both* initial and continuation / reauthorization requests.

SECTION 6: FOR CONTINUATION OF THERAPY / REAUTHORIZATION REQUESTS ONLY

10. From baseline motor milestone score to most recent motor milestone score:

    Has the patient received a clinical benefit from Spinraza® therapy as evidenced by improvement or maintenance of motor skills or ability to sit, crawl, stand or walk, or new motor milestones?

    ☐ Yes ☐ No

11. When considering all categories of motor milestones, are the number of categories that show improvement greater than the number that shows worsening?

    ☐ Yes ☐ No

Patient's Name: _____

SECTION 7: ADDITIONAL CLINICAL INFORMATION

☐ Attachments

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Prescriber Signature: _____ **Date:** _____

(Proxy signatures are not accepted.)

Mail requests to:

Magellan Medicaid Administration, LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-800-424-1664

Fax this form to 1-800-424-7402