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FLORIDA MEDICAID

Prior Authorization

Spinraza® (nusinersen)

(Note: Maximum Length of Approval is 8 Months)

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

MEDICATION	QUANTITY	DIRECTIONS
Spinraza		

Diagnosis _____

Provider Specialty _____

☐ **Initiation of Therapy** **OR** ☐ **Continuation of Therapy**

MEDICAL HISTORY

Invasive Ventilation (≤ 16 hours per day)	☐ Yes ☐ No	**Scoliosis**	☐ Yes ☐ No
Non-invasive ventilation for at least 12 hours per day	☐ Yes ☐ No	**Spine Surgery**	☐ Yes ☐ No
Tracheostomy	☐ Yes ☐ No		

NOTE: OFFICIAL LAB REPORTS AND TESTING MUST BE SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST. FORM AND LAB DATA MUST BE COMPLETED IN FULL.

Official Genetic Testing Confirming Diagnosis: ☐ **Yes** ☐ **No**

Date of Test: _____

Assessment Motor Milestone Score: ☐ **Yes** ☐ **No**

Name of Assessment: _____

Date of Assessment: _____

Platelet Count: _____

Date of lab: _____

Coagulation Laboratory Testing : ☐ **Yes** ☐ **No**

Date of lab: _____

Quantitative Spot Urine Testing: ☐ **Yes** ☐ **No** **Date of lab:** _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

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