UnitedHealthcare Community Plan

Spinraza - Arizona
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have a diagnosis of spinal muscular atrophy (SMA) type I, II, or III?**
□ Yes □ No	**Have medical records (e.g., chart notes, laboratory values) been submitted confirming the mutation or deletion of genes in chromosome 5q resulting in one of the following?** *(If yes, check which applies)* □ Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) □ Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]
□ Yes □ No	**Is there submission of medical records (e.g. chart notes, laboratory values) confirming the patient has at least 2 copies of SMN2?**
□ Yes □ No	**Is the patient dependent on either of the following?** □ Invasive ventilation or tracheostomy □ Use of non-invasive ventilation beyond use for naps and nighttime sleep
□ Yes □ No	**Have medical records been submitted of the baseline exam of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability?** *(If yes, check which applies)* □ Hammersmith Infant Neurological Exam Part 2 (HINE-2) (infant to early childhood) □ Hammersmith Functional Motor Scale Expanded (HFMSE) □ Upper Limb Module (ULM) Test (Non ambulatory) □ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
□ Yes □ No	**Is this prescribed by, or in consultation with, a neurologist with expertise in the treatment of SMA?**
□ Yes □ No	**Is this to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures?**
□ Yes □ No	**Is dosing in accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 12 mg for each loading dose?**
CONTINUATION OF THERAPY	
□ Yes □ No	**Have medical records been submitted with the most recent results (< 1 month prior to request) documenting a positive clinical response demonstrated by at least ONE of the following exams?** □ **HINE-2 milestones:** □ Improvement or maintenance of previous improvement in ability to kick □ Improvement or maintenance of previous improvement in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp □ Continued clinical benefit based on the prescriber's assessment **AND** □ The patient exhibited improvement or maintenance of previous improvement in more HINE-2 motor milestones than worsening, from pretreatment baseline (net positive improvement) □ Achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk) □ Continued clinical benefit based on the prescriber's assessment **OR** □ **HFMSE or ULM or CHOP INTEND:** □ Improvement or maintenance of previous improvement in score from pretreatment baseline □ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so □ Continued clinical benefit based on the prescriber's assessment
□ Yes □ No	**Is the dosing in accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 12 mg every 4 months, starting 4 months after the last loading dose?**

Provider Signature: _____ **Date:** _____