

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#

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Date of Birth (MM/DD/YYYY)

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Recipient's Full Name

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Prescriber's Full Name

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Prescriber's NPI

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Prescriber Phone Number

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Prescriber Fax Number

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MEDICATION	QUANTITY	DIRECTIONS
Spinraza		

Diagnosis _____

Provider Specialty _____

Initiation of Therapy OR Continuation of Therapy

MEDICAL HISTORY

Invasive Ventilation (≤ 16 hours per day)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-invasive ventilation for at least 12 hours per day	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spine Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tracheostomy	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Test: _____	Assessment Motor Milestone Score: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Assessment: _____ Date of Assessment: _____
Platelet Count: _____ Date of lab: _____	Coagulation Laboratory Testing : <input type="checkbox"/> Yes <input type="checkbox"/> No Date of lab: _____
Quantitative Spot Urine Testing: <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-855-258-1593

02.15.2024

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