

## FLORIDA MEDICAID

**Prior Authorization** 

Spinraza<sup>®</sup> (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		DIF	RECTIONS		
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	Yes No	Spine Surgery	🗌 Yes	No	
12 hours per day 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:		Assessment Motor Milestone Score: 🗌 Yes 🗌 No			
Yes No   Date of Test: Date of Assessment:					
Platelet Count: Date of lab:	Coagulation Laborate		🗌 Yes 🗌 No		
Quantitative Spot Urine Testing:					
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 Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient,					
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