Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Spinraza® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Spinal muscular atrophy (SMA)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Spinraza® prescribed by or in consultation with a neurologist who has experience treating SMA? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, also answer the following questions: Is the recipient maintaining neurological status? ❑ **Yes** ❑ **No**

Is the recipient tolerating therapy? ❑ **Yes** ❑ **No**

Has the recipient been on therapy for 12 months or more? ❑ **Yes** ❑ **No**

If "yes" to the above question, has the recipient experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-855-455-3303.

Office use only: Spinraza_NevadaMedicaid_2019May-W