

Aetna Better Health® of 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.

Reci	Recipient's Medicaid ID# Date of Bi													Birth (MM/DD/YYYY)															
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Reci	pient	's Fu	ll Na	me						1							1												
Prescriber's Full Name													<u> </u>					<u>'</u>					•						
Prescriber's NPI																	1												
Prescriber Phone Number													Prescriber Fax Number																
											Tresenser Fax reamser																		
MEDICATION QUANTITY												DIRECTIONS																	
Spinraza																													
Dia	Diagnosis																												
Pro	vide	r Sp	ecia	alty_																									
	☐ Initiation of Therapy OR ☐ Continuation of Therapy																												
MEDICAL HISTORY																													
Invasive Ventilation												1	Sco	lios	is] Ye	S		□Nc)						
(≤ 16 hours per day) Non-invasive ventilation for at least											<u>.</u> г	∃No		Sni	ne S	urac)r\/		Г	∃Ye:	<u> </u>	Г	□No						
12 hours per day											, L	1110		Орі	116 0	urge	, y		'	J 1 C.	3	٠		,					
Tra	Tracheostomy ☐ Yes											J No)						-										
NOTE: OFFICIAL LAB REPORTS AND TESTING MUST BE SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST.															ST.														
FORM AND LAB DATA MUST BE COMPLETED IN FULL. Official Genetic Testing Confirming Diagnosis: Assessment Motor Milestone Score:																													
Om														Assessment Motor Milestone Score: Name of Assessment:												9S [_l NC)	
Dat	Date of Test:													Date of Assessment:															
Pla	Platelet Count:													Coagulation Laboratory Testing :											☐ Yes ☐ No				
Dat	Date of lab:													Date of lab:															
Quantitative Spot Urine Testing:																													
Pres	rescriber's Signature:															_ Da	ate:									_			

REQUIRED FOR REVIEW: 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 completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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