# 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.**

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 | DIRECTIONS |
|---|---|---|
| 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 12 hours per day** | ☐ Yes ☐ No | **Spine Surgery** | ☐ Yes ☐ No |
| **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:**
☐ **Yes** ☐ **No**
**Date of Test:** _____

**Assessment Motor Milestone Score:** ☐ **Yes** ☐ **No**
**Name of Assessment:** _____
**Date of Assessment:** _____

**Platelet Count:** _____
**Date of lab:** _____

**Coagulation Laboratory Testing :** ☐ **Yes** ☐ **No**
**Date of lab:** _____

**Quantitative Spot Urine Testing:** ☐ **Yes** ☐ **No** **Date of lab:** _____

**Prescriber's Signature:** _____ **Date:** _____

**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.