

## Aetna Better Health® of 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 DIRECTIONS QUANTITY** Spinraza Diagnosis \_\_\_ Provider Specialty\_\_\_\_\_ Initiation of Therapy OR **Continuation of Therapy MEDICAL HISTORY** Yes **Invasive Ventilation** No Scoliosis Yes No ( ≤ 16 hours per day) Yes Non-invasive ventilation for at least 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: No Yes Name of Assessment: \_\_\_\_\_ Date of Test: Date of Assessment: \_\_ Coagulation Laboratory Testing : Platelet Count: Yes No Date of lab: \_ Date of lab: Quantitative Spot Urine Testing: Yes Date of lab: \_\_\_\_\_ No

**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.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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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