



# State of Louisiana

Louisiana Department of Health  
Bureau of Health Services Financing

## PRIOR AUTHORIZATION REQUEST COVERSHEET

Please check the member's appropriate health plan listed below:

### Retail Pharmacy Requests

- Prime Therapeutics State Government Solutions LLC**  
*For Aetna Better Health of Louisiana, AmeriHealth Caritas Louisiana, Healthy Blue, Humana, LA Healthcare Connections, United Healthcare*  
Phone: 1-800-424-1664 / Fax: 1-800-424-7402
- Fee-for-Service (FFS) Louisiana Legacy Medicaid**  
Phone: 1-866-730-4357 / Fax: 1-866-797-2329 / [www.lamedicaid.com](http://www.lamedicaid.com)

### Requests for Medications Through Medical Benefit

- Aetna Better Health of Louisiana – Medical Benefit – Physician Administered Drugs**  
Phone: 1-855-242-0802 / Fax: 1-844-227-9205 / TTY: 1-855-242-0802, 711
- AmeriHealth Caritas Louisiana**  
Phone: 1-800-684-5502 / Fax: 1-855-452-9131 [www.amerihealthcaritasla.com/pharmacy/priorauth.aspx](http://www.amerihealthcaritasla.com/pharmacy/priorauth.aspx)
- Healthy Blue – Medical Injectables**  
Phone: 1-844-521-6942 (M-F 7a-7p; Sat 9a-1p CT) / Fax: 1-844-487-9291  
CenterX®: Submit through EPIC EMR
- Humana – Professionally Administered Drugs**  
[Availity.com](http://Availity.com) (registration required)  
Phone: 1-866-461-7273 (M-F 7a-10p CT) / Fax: 1-888-447-3430 (request form at [Humana.com/medPA](http://Humana.com/medPA))
- LA Healthcare Connections – Physician Administered Medication (Buy and Bill)**  
Phone: 1-866-595-8133 / Fax: 1-866-925-3006
- United Healthcare – Medical Benefit**  
Phone: 1-888-397-8129 / Fax: 1-877-271-6290 / [www.UHCprovider.com](http://www.UHCprovider.com)

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**LOUISIANA MEDICAID  
NUSINERSEN (SPINRAZA®) CLINICAL AUTHORIZATION FORM**

<b>SECTION I – SUBMISSION</b>							
Submitted to:			Phone:		Fax:		Date:
<b>SECTION II – PRESCRIBER INFORMATION</b>							
Last Name, First Name MI:				NPI# or Plan Provider #:		Specialty:	
Address:				City:		State:	Zip Code:
Phone:		Fax:		Office Contact Name:		Contact Phone:	
<b>SECTION III – PATIENT INFORMATION</b>							
Last Name, First Name MI:			DOB:		Phone:		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Address:				City:		State:	ZIP Code:
Plan Name (if different from Section I):			Member or Medicaid ID #:			Plan Provider ID:	
Is the patient currently a hospital inpatient getting ready for discharge? ____ Yes    ____ No    Date of Discharge: _____ EPSDT Support Coordinator contact information, if applicable: _____							
<b>SECTION IV – PRESCRIPTION DRUG INFORMATION</b>							
<b>Requested Drug Name: Nusinersen (Spinraza®)</b>							
Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:		Expected Therapy Duration/Start Date:
<p>To the best of your knowledge this medication is:</p> <p>____ New therapy/Initial request</p> <p>____ Continuation of therapy/Reauthorization request</p> <p>If continuation of therapy, date of initiation: _____</p> <p>Has this medication been prescribed by, or in consultation with, a physician who specializes in the treatment of spinal muscular atrophy? ____ Yes    ____ No</p> <p>Has this recipient previously been treated with onasemnogene abeparvovec-xioi (Zolgensma®)? ____ Yes    ____ No          Onasemnogene abeparvovec-xioi treatment date _____ and result _____</p> <p>Will the patient receive the drug in the physician's office? ____ Yes ____ No</p> <p>If no, list name and NPI of servicing provider/facility: _____</p> <p>If yes, please complete the following:</p> <p>HCPCS/CPT-4 Code: _____ NDC#: _____ Dose Per Administration: _____</p> <p>Other Codes: _____</p>							
<b>SECTION V – PATIENT CLINICAL INFORMATION</b>							
Does the patient have a diagnosis of spinal muscular atrophy (SMA)? ____ Yes ____ No							
If yes, date diagnosed: _____							
If yes, what type of SMA does the patient have? (Select one below.)							
Type I (infantile onset or Werdnig-Hoffman disease [ICD-10-CM G12.0], symptoms are present at birth or by 6 months of age, unable to sit without assistance)							
Type II (intermediate SMA [ICD-10-CM G12.1], symptoms develop between 6 months and 12 months of age, able to sit unassisted but unable to stand or walk independently)							
Type III (mild SMA or Kugelberg-Welander disease (ICD-10-CM G12.1), usually diagnosed between early childhood and adolescence, able to stand and walk independently but may lose this ability later in life)							

Has the diagnosis been confirmed by genetic testing?†  Yes  No

If yes, did the testing confirm 5q SMA homozygous gene mutation, homozygous gene deletion, or compound heterozygote?†  
 Yes  No

† Genetic testing information must be documented in the chart below

Date of Test	Results of Genetic Testing

Does the patient require ventilator support for 16 or more hours per day?  Yes  No

If yes, date of initiation: \_\_\_\_\_

Motor Milestone Test*	Score	Measurement Date	Specialty of Provider Administering Test
<b>For recipients ≤ 2 years of age:</b> Hammersmith Infant Neurological Examination Section 2 (HINE-2)			
<b>For ambulatory recipients ≥ 3 years of age:</b> Hammersmith Functional Motor Scale Expanded (HFMSSE)			
<b>For non-ambulatory recipients &gt; 3 years of age:</b> Revised Upper Limb Module (RULM)			

\*Results of most recent motor milestone test MUST be included for both initial and continuation / reauthorization requests.

#### SECTION VI — FOR CONTINUATION OF THERAPY / REAUTHORIZATION REQUESTS ONLY

From baseline motor milestone score to most recent motor milestone score:

Has the patient received a clinical benefit from Spinraza® therapy as evidenced by improvement or maintenance of motor skills or ability to sit, crawl, stand or walk, or new motor milestones?  Yes  No

When considering all categories of motor milestones, are the number of categories that show improvement greater than the number that shows worsening?  Yes  No

#### SECTION VII — ADDITIONAL CLINICAL INFORMATION

**By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.**

Signature of Prescriber: \_\_\_\_\_

Date: \_\_\_\_\_