



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#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Table with columns: MEDICATION (Spinraza), QUANTITY, DIRECTIONS

Diagnosis

Provider Specialty

Initiation of Therapy OR Continuation of Therapy

MEDICAL HISTORY

Table for Medical History with rows for Invasive Ventilation, Non-invasive ventilation, Tracheostomy, Scoliosis, Spine Surgery

NOTE: OFFICIAL LAB REPORTS AND TESTING MUST BE SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST. FORM AND LAB DATA MUST BE COMPLETED IN FULL.

Table for Genetic Testing and Laboratory Testing with rows for Genetic Testing, Platelet Count, Coagulation Laboratory Testing, Quantitative Spot Urine Testing

Prescriber's Signature: Date:

REQUIRED FOR REVIEW: All 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 this form to 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593

02.15.2024

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