Nevada Medicaid
Spinraza® Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Spinal muscular atrophy (SMA)

❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Is Spinraza® prescribed by or in consultation with a neurologist who has experience treating SMA? ☐ **Yes** ☐ **No**

Reauthorization:

If this is a reauthorization request, also answer the following questions

Is the recipient maintaining neurological status? ☐ **Yes** ☐ **No**

Is the recipient tolerating therapy? ☐ **Yes** ☐ **No**

Has the recipient been on therapy for 12 months or more? ☐ **Yes** ☐ **No**

If "yes" to the above question, has the recipient experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.