Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

# Spinraza
# (nusinersen)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Physician Name: | | | *Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.* | | |
| Specialty: | * DEA, NPI or TIN: | | | | |
| Office Contact Person: | | | * Patient Name: | | |
| Office Phone: | | | * Cigna ID: | * Date of Birth: | |
| Office Fax: | | | * Patient Street Address: | | |
| Office Street Address: | | | City: | State: | Zip: |
| City: | State: | Zip: | Patient Phone: | | |

**Urgency:**
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

**Medication Requested:** ☐ Spinraza ICD10:

Direction for use and Quantity: Duration of therapy:

**Where will this medication be obtained?**
☐ Accredo Specialty Pharmacy ** ☐ Other (please specify):

**Medication orders can be placed with Accredo via Fax 877.327.8413

Please indicate any CPT codes that will be billed for administration: _____

**Facility and/or doctor dispensing and administering medication:**

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

**Clinical Information**

**What is the indication or diagnosis?**
☐ Spinal Muscular Atrophy (SMA) - Treatment
☐ All others

Is the requested medication being prescribed by a physician who has consulted with or who specializes in management of patients with spinal muscular atrophy and/or neuromuscular disorders? Yes ☐ No ☐

Will the requested medication be given in combination with Evrysdi (risdiplam oral solution and tablets)? Yes ☐ No ☐

Does the patient have permanent ventilator dependence? Yes ☐ No ☐

Does the patient have complete paralysis of all limbs? Yes ☐ No ☐

Is the patient currently receiving Spinraza? Yes ☐ No ☐

(if currently receiving) Will each Spinraza dose be administered once every 4 months as maintenance therapy? Yes ☐ No ☐

(if currently receiving) Has the patient had a genetic test confirming the diagnosis of spinal muscular atrophy with bi-allelic pathogenic

variants in the survival motor neuron 1 (SMN1) gene? Note: Pathogenic variants may include homozygous deletion, compound heterozygous mutation, or a variety of other rare mutations. Yes ☐ No ☐

(if currently receiving) Does the patient have two or three survival motor neuron 2 (SMN2) gene copies? Yes ☐ No ☐

(if currently receiving) Does the patient have four survival motor neuron 2 (SMN2) gene copies? Yes ☐ No ☐
(if currently receiving) Does the patient have objective signs consistent with spinal muscular atrophy Types 1, 2, or 3? Yes ☐ No ☐

(if currently receiving) Is documentation being provided to confirm that the patient had a positive clinical response (for example, improvement or stabilization) from pretreatment baseline status (that is, WITHIN THE PAST 4 MONTHS) with Spinraza from one of the following [(1), (2), (3), (4), (5), (6), or (7)]: (1) Bayley Scales of Infant and Toddler Development; OR (2) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND); OR (3) Hammersmith Functional Motor Scale Expanded (HFMSE); OR (4) Hammersmith Infant Neurological Exam Part 2 (HINE-2); OR (5) Motor Function Measure-32 Items (MFM-32); OR (6) Revised Upper Limb Module (RULM) test; OR (7) World Health Organization motor milestone scale? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information. Yes ☐ No ☐

(if currently receiving) Is documentation being provided to confirm that according to the prescribing physician, the patient has responded to Spinraza and continues to have benefit from ongoing Spinraza therapy by the most recent (that is, WITHIN THE PAST 4 MONTHS) physician monitoring/assessment tools? Please Note: Examples include pulmonary function tests showing improvement, bulbar function test results suggest benefits, reduced need for respiratory support, decrease in the frequency of respiratory infections or complications and/or prevention of permanent assisted ventilation. PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information. Yes ☐ No ☐

(if NOT currently receiving) Is documentation being provided to confirm a baseline motor ability assessment that suggests spinal muscular atrophy (based on age, motor ability, and development) has been performed from ONE of the following exams: (a, b, c, d, e, f, or g): a) Bayley Scales of Infant and Toddler Development; OR b) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND); OR c) Hammersmith Functional Motor Scale Expanded (HFMSE); OR d) Hammersmith Infant Neurological Exam Part 2 (HINE-2); OR e) Motor Function Measure-32 Items (MFM-32); OR f) Revised Upper Limb Module (RULM) test; OR g) World Health Organization motor milestone scale? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information. Yes ☐ No ☐

(if NOT currently receiving) Is documentation being provided to confirm that the patient had a genetic test confirming the diagnosis of spinal muscular atrophy with bi-allelic pathogenic variants in the survival motor neuron 1 (SMN1) gene? Note: Pathogenic variants may include homozygous deletion, compound heterozygous mutation, or a variety of other rare mutations. PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information. Yes ☐ No ☐

(if NOT currently receiving) Is documentation being provided to confirm that the patient has two or three survival motor neuron 2 (SMN2) gene copies? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information. Yes ☐ No ☐

(if NOT currently receiving and does NOT have two or three SMN2 gene copies) Is documentation being provided to confirm that the patient has four survival motor neuron 2 (SMN2) gene copies? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information. Yes ☐ No ☐

(if NOT currently receiving and has four SMN2 gene copies) Is documentation being provided to confirm that the patient has objective signs consistent with spinal muscular atrophy Types 1, 2, or 3? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information. Yes ☐ No ☐

(if NOT currently receiving) Has the patient received Zolgensma (onasemnogene abeparvovec-xioi intravenous infusion) or Itvisma (onasemnogene abeparvovec-brve intrathecal injection) in the past? Yes ☐ No ☐

(if NOT currently receiving) Does the prescribing physician confirm that the patient has not previously received Zolgensma or Itvisma?

☐ It is confirmed by the prescribing physician that the patient has not previously received Zolgensma or Itvisma.
☐ It is not confirmed

(if NOT currently receiving) Does one of the following dosing regimens apply to the patient: Low-Dose Regimen; OR High-Dose Regimen?
☐ Low-dose regimen
☐ High-dose regimen
☐ None of the above dosing regimens apply

(if low-dose) Does the prescribed low-dose regimen dosing meet the following: Initial therapy of 12 mg intrathecally as four loading doses of which the first three loading doses should be given at 14-day intervals and the fourth loading dose should be given 30 days after the third dose AND the maintenance dose is 12 mg intrathecally once every 4 months and is started 4 months after the last loading dose? Yes ☐ No ☐

(if high-dose) Does the prescribed high-dose regimen dosing meet the following: Initial therapy of 50 mg intrathecally followed by a second 50 mg dose 14 days later AND the maintenance dose is 28 mg intrathecally once every 4 months and is started 4 months after the last loading dose? Yes ☐ No ☐

(if Currently receiving) Does one of the following dosing regimens apply to the patient: Low-Dose Regimen; OR Transitioning from the Low-Dose Regimen to the High-Dose Regimen; OR High-Dose Regimen?

☐ Low-dose regimen
☐ Transitioning from the Low-Dose Regimen to the High-Dose Regimen
☐ High-Dose Regimen
☐ None of the above dosing regimens apply

(if low-dose) Is the prescribed low-dose regimen maintenance dose 12 mg intrathecally once every 4 months and is started 4 months after the last loading dose? Note: If the last dose was a missed maintenance dose please provide how long ago the last dose was given. Yes ☐ No ☐

(if transitioning from low to high-dose) Is the prescribed low-dose regimen to the high-dose regimen transition dose one 50 mg intrathecal dose given at least 4 months after the last 12 mg maintenance dose? Yes ☐ No ☐

(if high-dose) Is the prescribed high-dose regimen maintenance dose 28 mg intrathecally once every 4 months and is started 4 months after the last loading dose? Note: If the last dose was a missed maintenance dose please provide how long ago the last dose was given. Yes ☐ No ☐

**Additional pertinent information***:*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:**_____ **Date:**_____

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