HIGHMARK HEALTH OPTIONS

Updated: 07/2025
Approved: 06/2025

Request for Prior Authorization for Spinraza (nusinersen)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Spinraza (nusinersen) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Spinraza (nusinersen) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of Spinal Muscular Atrophy (SMA) and the following criteria is met:

- Documentation diagnosis was confirmed by genetic testing
- Must be prescribed by or in consultation with a neurologist experienced in the treatment of SMA
- Documentation of the following laboratory tests at baseline (pre-treatment) and prior to each administration:
  - Platelet count (PLT)
  - Prothrombin time (PT)
  - Activated patrial thromboplastin time (aPTT)
  - Quantitative spot urine protein testing
- Documentation of a baseline (pre-treatment) motor exam using at least one of the following measures of motor function:
  - Hammersmith Infant Neurologic Exam (HINE)
  - Hammersmith Functional Motor Scale (HFMSE)
  - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
- Must not be used concomitantly with Evrysdi
- **Initial Duration of Approval:** 6 months

- **Reauthorization Criteria:**
  - Member must continue to satisfy all criteria required for initial approval
  - Documentation showing clinically significant improvement in SMA associated symptoms, such as lack of progression, stabilization, or decreased decline in motor function, when compared to baseline (pre-treatment). Motor exams must be conducted within **60 days prior to continuation request** and must include baseline (pre-treatment) results documenting a positive clinical response from to Spinraza therapy as demonstrated by at least one of the following exams:
    - HINE
    - HFMSE
    - CHOP-INTEND
- NOTE: For older individuals (> 24 months), alternative means of motor assessment (e.g., Medical Research Council [MRC] strength test, 6-Minute Walk Test [6MWT], Revised Upper Limb Module [RULM] test, Pulmonary Function Test [PFT]) are appropriate alternatives.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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SPINRAZA (NUSINERSEN) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Does the member have a diagnosis of spinal muscular atrophy (SMA) confirmed by genetic testing? (*please submit documentation of the test)* ☐ Yes ☐ No

Is the requested SMA medication being prescribed by or in consultation with a neurologist with experience treating and ongoing management of members with SMA? ☐ Yes ☐ No

Has the member had a baseline assessment of motor function milestones? ☐ Yes ☐ No
Please select all that apply and submit documentation of baseline assessment:
- ☐ Hammersmith Functional Motor Scale Expanded (HFMSE)
- ☐ Hammersmith Infant Neurologic Exam (HINE)
- ☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)

Will the member be using the medication concomitantly with Evrysdi (risdiplam)? ☐ Yes ☐ No

Please provide documentation of the following lab values below (*baseline and prior to each administration):*

Lab	Baseline	Most Recent Value	Date Taken
Platelet count (PLT)			
Prothrombin time (PT)			
Activated partial thromboplastin time (aPTT)			
Quantitative spot urine protein testing			

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SPINRAZA (NUSINERSEN)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

MEDICAL HISTORY (Complete for ALL requests)
CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Is there documentation of an annual evaluation by a neurologist with experience treating and ongoing management of members with SMA? ☐ Yes ☐ No

Is there documentation demonstrating the member had significant improvement in SMA associated symptoms, such as lack of progression, stabilization, or decreased decline in motor function, when compared to baseline (pre-treatment)? *Motor exams must be conducted within **60 days prior to continuation request** and must include baseline (pre-treatment) results.*
☐ Yes, documentation is provided ☐ No

Please provide documentation of the following lab values below (*baseline and prior to each administration):*

Lab	Baseline	Most Recent Value	Date Taken
Platelet count (PLT)			
Prothrombin time (PT)			
Activated partial thromboplastin time (aPTT)			
Quantitative spot urine protein testing			

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date