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:

Is this new start or continuation of therapy?
☐ new start of therapy
☐ continued therapy

(if continued therapy) Does your patient have documentation of a positive clinical response (for example, improvement or stabilization) since initiating Spinraza compared with pretreatment baseline status as evidenced by one of the following exams, or prescriber monitoring/assessment tools (based on age and motor ability), in the last 4 months:
A. Bayley Scales of Infant and Toddler Development;
B. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND);
C. Hammersmith Infant Neurological Exam Part 2 (HINE-2);
D. Hammersmith Functional Motor Scale Expanded (HFMSE);
E. Motor Function Measure-32 Items (MFM-32);
F. Revised Upper Limb Module (RULM) Test;
G. 6-Minute Walk Test (6MWT);
H. World Health Organization motor milestone scale;
I. Physician monitoring tools (pulmonary function test, bulbar function, and/or reduced need for respiratory support)?
☐ Yes ☐ No

(if yes) Please provide specific examples of improvement or stabilization from pretreatment baseline status.

(if no) Please provide support for continued use.

(if continuation not met) Has the patient missed maintenance doses? ☐ Yes ☐ No

(if missed dose) How long has it been since the patient's last dose?

☐ at least 8 months but less than 16 months from the last dose
☐ at least 16 months but less than 40 months from the last dose
☐ at least 40 months from the last dose
☐ other

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 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

Diagnosis
Will the requested drug be used for the treatment of Spinal Muscular Atrophy (SMA)?
☐ Yes
☐ No *(please specify):*

(if SMA) Does the patient have complete paralysis of all limbs? Yes ☐ No ☐

Clinical Information
****This drug requires supportive documentation (chart notes, genetic test results, etc) be attached with this request****

Did your patient undergo genetic testing to confirm the diagnosis of Spinal Muscular Atrophy (SMA)?
☐ Yes (please include a copy of these results)
☐ No or Unknown

Does the patient have bi-allelic mutations in the survival motor neuron 1 (SMN1) gene? Yes ☐ No ☐

(if genetic testing) Were the mutations in the survival motor neuron 1 (SMN1) gene reported as at least one of these?

☐ homozygous deletion
☐ homozygous mutation
☐ compound heterozygous mutation
☐ MORE THAN ONE of the above
☐ other or unknown

(if other/unknown or MORE THAN ONE of the above) Please specify the results. If more than one were met, please list which mutations were met.

Did the patient's genetic testing or other testing include results of SMN2 (survival motor neuron 2) gene copies? Yes ☐ No ☐

(if SMN2) What were the results?

☐ Patient has 1 copy of the SMN2 gene
☐ Patient has 2 to 3 copies of the SMN2 gene
☐ Patient has 4 or greater copies of the SMN2 gene
☐ Patient has 5 or greater copies of the SMN2 gene
☐ Other or unknown

(if 4 copies of SMN2) Which subtype of SMN is your patient diagnosed with?

☐ Type 0 (prenatal)
☐ Type 1 (severe, Werdnig-Hoffmann Disease)
☐ Type 2 (intermediate)
☐ Type 3 (mild)
☐ Type 4 (adult)

Please specify objective signs and symptoms that support the selected subtype.

(if other or unknown) Please specify the results.

Prior to starting the requested drug, did your patient have a baseline motor ability assessment that suggested spinal muscular atrophy (based on age, motor ability, and development)? Yes ☐ No ☐

Please confirm which of the following assessments was used.

☐ Bayley Scales of Infant and Toddler Development
☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
☐ Hammersmith Functional Motor Scale Expanded (HFMSE)
☐ Hammersmith Infant Neurological Exam Part 2 (HINE-2)
☐ Motor Function Measure-32 Items (MFM-32)
☐ Revised Upper Limb Module (RULM) Test
☐ 6-Minute Walk Test (6MWT)
☐ World Health Organization motor milestone scale
☐ None of the above

Was the patient previously treated with Zolgensma? Yes ☐ No ☐

(if yes) Have at least 60 days passed since patient last received Zolgensma? Yes ☐ No ☐

(if yes) Does the patient have a documented clinical decline of minimally important clinical difference from pre-treatment baseline or highest post-treatment score achieved on one of the following motor exams (a, b, c, or d): a. CHOP INTEND: Decline of at least 4 points; b. HFMSE: Decline of at least 3 points; c. HINE-2: Decline of at least 1 point; d. RULM: Decline of at least 2 points? Yes ☐ No ☐

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

Does the patient have permanent ventilator dependence (defined as tracheostomy or ventilatory support for at least 16 hours per day for more than 21 continuous days in the absence of an acute reversible event)? Yes ☐ No ☐

Besides Spinraza, other treatment options include Evrysdi. Which of the following best describes your patient's situation?
☐ The patient is NOT taking Evrysdi, nor will they in the future. Spinraza is the only drug the patient is/will be using.
☐ The patient is currently on Evrysdi, but this drug will be stopped and Spinraza will be started.
☐ The patient is currently on Evrysdi, and Spinraza will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH Spinraza AND Evrysdi.
☐ other/unknown

(if concurrent) Please provide the rationale for concurrent use.

Please provide chart notes.

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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