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United Healthcare Community Plan

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#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

MEDICATION	QUANTITY	DIRECTIONS
Spinraza		

Diagnosis _____

Provider Specialty _____

☐ **Initiation of Therapy** **OR** ☐ **Continuation of Therapy**

MEDICAL HISTORY

Invasive Ventilation (≤ 16 hours per day)	☐ Yes ☐ No	**Scoliosis**	☐ Yes ☐ No
Non-invasive ventilation for at least 12 hours per day	☐ Yes ☐ No	**Spine Surgery**	☐ Yes ☐ No
Tracheostomy	☐ Yes ☐ No		

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

Official Genetic Testing Confirming Diagnosis: ☐ **Yes** ☐ **No** **Date of Test:** _____	**Assessment Motor Milestone Score:** ☐ **Yes** ☐ **No** **Name of Assessment:** _____ **Date of Assessment:** _____
Platelet Count: _____ **Date of lab:** _____	**Coagulation Laboratory Testing :** ☐ **Yes** ☐ **No** **Date of lab:** _____
Quantitative Spot Urine Testing: ☐ **Yes** ☐ **No** **Date of lab:** _____	

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:
1-800-310-6826

02.01.2025