Reset Form | Print Form

sunshine health

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-833-546-1507
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720
Call 1-866-399-0928 to request a 72-hour supply of medication.
Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

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.