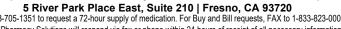
## MEDICATION PRIOR AUTHORIZATION REQUEST FORM FAX this completed form to 1-888-865-6531

OR Mail request to: Envolve Pharmacy Solutions Prior Authorization Dept.







Call 1-833-705-1351 to request a 72-hour supply of medication. For Buy and Bill requests, FAX to 1-833-823-0001. Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of all necessary information, except 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)

**Health Plan** 

PERATED BY SUNSHINE HEALTH

|  | Note: Form | <u>n must b</u>                   | e comp   | oleted i      | <u>ın tull. A</u> | <u>n incon</u> | npiete  | torm  | ı may | be re | eturn | ea.  |       |     |     |    |
|--|------------|-----------------------------------|----------|---------------|-------------------|----------------|---------|-------|-------|-------|-------|------|-------|-----|-----|----|
| Recipient's Medicaid ID#                       |            |                                   | Date o   | of Birth (    | ( <u>MM</u> /DD/  | <u> </u>       |         |       |       |       |       |      |       |     |     |    |
|  |            |                                   |          | 1             |                   | 1              |         |       |       |       |       |      |       |     |     |    |
| Recipient's Full Name                          |            |                                   |          |               | L                 |                | 1 1     |       |       |       |       |      |       |     |     |    |
|  |            |                                   |          |               |                   |                |         |       |       |       |       |      |       |     |     |    |
| Prescriber's Full Name                         |            |                                   |          |               | <u> </u>          | 1 1            |         |       | _     | _     |       |      |       |     |     | =  |
|  |            |                                   |          |               |                   |                |         |       |       |       |       |      |       |     |     |    |
| Prescriber's NPI                               |            |                                   |          |               |                   | 1 1            |         |       |       |       |       |      |       |     |     |    |
|  |            |                                   |          |               |                   |                |         |       |       |       |       |      |       |     |     |    |
| Prescriber Phone Number Prescriber Fax Number  |            |                                   |          |               |                   |                |         |       |       |       |       |      |       |     |     |    |
|  | <b>-</b>   |                                   |          |               |                   |                |         |       | -     |       |       | -    |       |     |     |    |
|  |            |                                   |          |               |                   |                |         |       |       |       |       |      |       |     |     |    |
| MEDICATION QUANTITY Spinraza                   |            | DIRECTIONS                        |          |               |                   |                |         |       |       |       |       |      |       |     |     |    |
| Diagnosis                                      |            |                                   |          |               |                   |                |         |       |       |       |       |      |       |     |     |    |
| Diagnosis                                      |            |                                   |          |               |                   |                |         |       |       |       |       |      |       |     |     |    |
| Provider Specialty                             |            |                                   |          |               |                   |                |         |       |       |       |       |      |       |     |     | _  |
| Initiation of Thera                            | py OR      | Continu                           | uation o | of Ther       | ару               |                |         |       |       |       |       |      |       |     |     |    |
|  |            |                                   | ME       | EDICAL        | _ HISTO           | RY             |         |       |       |       |       |      |       |     |     |    |
| Invasive Ventilation<br>( ≤ 16 hours per day)  | Yes        | No                                | Sco      | Scoliosis     |                   |                | Yes No  |       |       |       |       |      |       |     |     |    |
| Non-invasive ventilation f<br>12 hours per day | Yes        | No                                | Spi      | Spine Surgery |                   |                | Yes No  |       |       |       |       |      |       |     |     |    |
| Tracheostomy                                   | Yes        | No                                | I.       |               |                   |                |         |       |       |       |       |      |       |     |     |    |
| NOTE: OFFICIAL LAB RE<br>FORM AND LAB D        |            |                                   |          |               |                   | TED W          | ТН ТН   | IE PF | RIOR  | AUTH  | IORIZ | ZATI | ION I | REQ | UES | T. |
| Official Genetic Testing C                     |            | Assessment Motor Milestone Score: |          |               |                   |                |         |       |       |       | No    |      |       |     |     |    |
| Yes No   | Nar        | me of As                          | sessm    | ent:          |                   |                |         |       |       |       |       |      |       |     |     |    |
| Date of Test:                                  | — Dat      | Date of Assessment:               |          |               |                   |                |         |       |       |       |       |      | _     |     |     |    |
| Platelet Count:                                | l l        | Coagulation Laboratory Testing :  |          |               |                   |                |         |       |       | s     | No    |      |       |     |     |    |
| Date of lab:                                   |            |                                   |          | Dat           | te of lab         | :              |         |       |       |       |       |      |       | _   |     |    |
| Quantitative Spot Urine T                      | esting:    | Yes                               | No       | Date o        | of lab: _         |                |         |       |       |       |       | _    |       |     |     |    |
| Prescriber's Signature:                        |            |                                   |          |               |                   |                | Date:   |       |       |       |       |      |       |     |     |    |
| i rescriber s Signature                        |            |                                   |          |               |                   |                | Date: _ |       |       |       |       |      |       |     |     |    |

REQUIRED FOR REVIEW: 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.

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