Print Form Reset Form



MEDICATION PRIOR AUTHORIZATION REQUEST FORM

FAX this completed form to 1-888-865-6531 OR Mail request to: Pharmacy Services Prior Authorization Dept.

5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-833-705-1351 to request a 72-hour supply of medication. For Buy and Bill requests, FAX to 1-833-823-0001. Pharmacy Services 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)

Note: Form must be completed in full. An incomplete form may be returned.

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ecipient's Medicaid ID# Date of Birth (MM/DD/YYYY)																			
			7		1														
Recipient's Full Name						1													
Prescriber's Full Name	Prescriber's Full Name																		
Prescriber's NPI																			
Prescriber Phone Number	 	_				scribe	riber Fax Number									T			
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						<u> </u>													
MEDICATION QUANTITY Spinraza				D	IREC	TIO	NS												
Оринага																			
Diagnosis																			
Provider Specialty																			
☐ Initiation of Therapy OR ☐ Continuation of Therapy																			
			DICAL	-	ORY														
Invasive Ventilation		Scoliosis Yes						s □ No											
(≤ 16 hours per day)	day)																		
Non-invasive ventilation for at least	Spin	Spine Surgery						Yes											
12 hours per day																			
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:					Assessment Motor Milestone Score:										☐ Yes ☐ No				
Date of Test:		Name of Assessment:													-				
		Date of Assessment:																	
Platelet Count:		Coagulation Laboratory Testing : Date of lab:									☐ Yes ☐ No								
Date of lab:	Date	of I	ab:										_						
Quantitative Spot Urine Testing:	☐ Yes	□ No [Date o	f lab									_						
Proscribor's Signature)əta:												
Prescriber's Signature: REQUIRED FOR REVIEW: All copies of medi-										oct ro									
labs. The provider must retain copies of all d				aiuati	ons and	recer	ii ciia	110	.cs), i	anu t	ne m	ostre	Cent	copi	es Of	ı erati	5U		

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