

## 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.

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Recipient's Medicaid ID# Date of Birth (MM/DD/YYYY)																				
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					' _															
Recipient's Full Name	Recipient's ruii Name															1				
Prescriber's Full Name	<u> </u>			l l	I.		-													
Prescriber's Full Name																				
Prescriber's NPI																				
Prescriber Phone Number		Prescriber Fax Number																		
Trescriber Friorie Number								116.	SCIID											
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MEDICATION QUANTITY						DIRECTIONS														
Spinraza		== 3																		
Diagnosis																				
Diagnosis		·																		
Provider Specialty																				
. ,																				
☐ Initiation of Therapy OR	☐ Initiation of Therapy OR ☐ Continuation of Therapy																			
MEDICAL HISTORY																				
				No S	Scoliosis						☐ Yes ☐ No									
( ≤ 16 hours per day)  Non-invasive ventilation for at I	east [	Yes	<u> </u>	No S	Spine Surgery					☐Yes					□ No					
12 hours per day						3	,			_										
Tracheostomy																				
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				
☐ Yes ☐ No		Name of Assessment:														_				
Date of Test:	C	Date of Assessment:													_					
Platelet Count:	c	Coagulation Laboratory Testing :										☐ Yes ☐ No								
Date of lab:						f lab	·										_			
Quantitative Spot Urine Testing:																				
Prescriber's Signature:																				
REQUIRED FOR REVIEW: All copies of labs. The provider must retain copies of						ations	s and	recer	nt cha	rt no	tes),	and t	he m	ost re	cent	copi	es of	relat	ed	

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