aetna®

Spinraza® (nusinersen) Injectable Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Neurologist** ☐ **Pediatrician** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Spinraza: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: ***(Clinical documentation must be submitted with request)***

☐ Yes ☐ No Does the patient have a documented diagnosis of spinal muscular atrophy (SMA)?
→ Please confirm the type of SMA: ☐ SMA Type I ☐ SMA Type II ☐ SMA Type III ☐ SMN Type IV

Please enter the number of SMN1 copies based on SMA diagnostic test results: _____

☐ Yes ☐ No Does the patient have a documented evidence of zero copies of SMN1?
→ ☐ Yes ☐ No Does the patient have 5q chromosome mutation?
→ Please confirm the type of 5q chromosome mutation:
☐ 5q SMA homozygous gene mutation ☐ 5q SMA homozygous gene deletion
☐ 5q SMA compound heterozygote ☐ Other-Explain: _____

☐ Yes ☐ No Has genetic testing been completed to confirm the diagnosis?
→ Please indicate the genetic test(s) that have been completed to confirm the diagnosis:
☐ Atypical Spinal Muscular Atrophy Advanced Sequencing Evaluation ☐ Kennedy's Disease (SBMA) DNA Test
☐ Spinal Muscular Atrophy Diagnostic Test ☐ SMA Plus (Reflexive) ☐ SMN DNA Sequencing Test
☐ SMN1 Deletion Analysis ☐ Spinal Muscular Atrophy Carrier Test ☐ Spinal Muscular Atrophy (SMA) Copy Number Analysis
☐ Spinal Muscular Atrophy (SMN1 and SMN2) ☐ Other-Explain: _____
Please enter the date genetic testing was completed. Date: ____/____/____
Please enter the findings of the genetic testing: _____

☐ Yes ☐ No Is the medication prescribed by or in consultation with a physician who specializes in treatment of SMA?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Continuation Requests:

At what age was Spinraza initiated? _____

Please provide the date of the last Spinraza treatment. Date: ____/____/____

Please indicate the patient response to therapy: ☐ No response ☐ Minimal response ☐ Adequate response ☐ Significant improvement

☐ Yes ☐ No Has the patient maintained or improved motor milestones?

→ Please indicate: ☐ Ability to sit unassisted ☐ Ability to stand ☐ Ability to walk

☐ Maintained milestones at ages when they would be expected to be lost

☐ Survived to ages unexpected considering the number of SMN2 gene copies

☐ Other-Explain: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.