NUSINERSEN (SPINRAZA) REQUEST FORM
HEALTH FIRST COLORADO (COLORADO’S MEDICAID PROGRAM)

✓ Spinraza requests will be reviewed on a case by case basis for all Health First Colorado Members who qualify under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.
✓ Requests must be submitted to the following inbox: epsdt@state.co.us
✓ Copies of all clinical documentation supporting the information below, along with the Spinraza Request Form, must be attached and submitted at the time of the request.
✓ Requests for Spinraza may receive a full approval, partial approval, a lack of information denial, or full medical necessity denial as determined by the Health First Colorado Chief Medical Director or his/her designee.
✓ The EPSDT program does not have an appeal process – the decision is final. A denied request can be resubmitted with additional medical information.

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**Provider Information**

Was SMA diagnosed by a neurologist experienced in the treatment of SMA? Yes ___ No___

✓ If Yes, name of neurologist: ______________________________.
✓ If No, name and specialty of diagnosing physician: ______________________________.

Is Spinraza being prescribed by a neurologist experienced in the treatment of SMA? Yes ___ No___

✓ If Yes, name of prescriber: ______________________________.
✓ If No, name and specialty of prescribing physician: ______________________________.

Will Spinraza be administered in a healthcare facility by a specialist experienced in performing lumbar punctures? Yes ___ No___ Name of facility: ______________________________.

Number of Spinraza doses requested: ______________________________.

Contact name (print): ______________________________. Phone: ______________________________.
Email: ___________________________________________________________________________________.
**Member Clinical Information**

Current Age: ___________.       Gender: ___________.      Ethnicity: ___________.

SMA clinical subtype: ______________________________.

Please indicate SMN1 mutation AND number of SMN2 gene copies:

__________________________________________________________________________________________________________.

Age at diagnosis of SMA: ______________________________.

Age at onset of SMA symptoms, if different than time of diagnosis: ______________________________.

Were the SMA symptoms documented by a neurologist using a motor exam? Yes ___ No__

Which of the following motor exam(s) were used for the Member’s **baseline** exam:

- ✓ Children ≤ 2 years old: Hammersmith Infant Neurological Examination Section 2 (HINE-2): Yes ___ No__ N/A__
- ✓ Children > 3 years old and ambulatory: Hammersmith Functional Motor Scale-Expanded (HFMSE): Yes ___ No__ N/A__
- ✓ Children’ > 3 years old and non-ambulatory: Upper Limb Module Test (ULM): Yes ___ No__ N/A__

Date of **baseline** motor exam(s): ______________________________.

Summary of results of the **baseline** motor exam(s):

__________________________________________________________________________________________________________.

Which of the following motor exam(s) were used for the Member’s **most recent** exam:

- ✓ Children ≤ 2 years old: Hammersmith Infant Neurological Examination Section 2 (HINE-2): Yes ___ No__ N/A__
- ✓ Children > 3 years old and ambulatory: Hammersmith Functional Motor Scale-Expanded (HFMSE): Yes ___ No__ N/A__
- ✓ Children’ > 3 years old and non-ambulatory: Upper Limb Module Test (ULM): Yes ___ No__ N/A__

Date of **most recent** motor exam(s): ______________________________.

Summary of results of the **most recent** motor exam(s):

__________________________________________________________________________________________________________.

Was the **most recent** motor exam(s) performed by the same provider who performed the baseline exam? Yes ___ No__
Does the Member require permanent ventilation? Yes ___ No___

- If Yes, describe type of ventilation required:
  ____________________________________________.

- If Yes, number of hours of permanent ventilation support required every 24 hours including naps: ________________________.

Does the Member require respiratory support such as noninvasive or assisted ventilation? Yes ___ No___

- If Yes, describe type of respiratory support required:
  ____________________________________________.

- If Yes, number of hours of respiratory support required every 24 hours including naps: ________________________.

Does the Member have stable baseline labs including, but not limited to, a PT, PTT, platelets, and quantitative urine protein testing? Yes ___ No___

Will the Member have labs drawn and monitored prior to each subsequent Spinraza dose? Yes ___ No___

Has the Member previously been treated with Spinraza: Yes ___ No___

If Yes, indicate the following:

- Number of Spinraza doses received: ________________________.

- Date(s) of previous Spinraza treatments:
  ____________________________________________.

- Did Member receive any previous Spinraza doses as part of an SMA clinical trial? Yes ___ No___

- If Yes, how many Spinraza doses were received as part of an SMA clinical trial: ________________________.

- Please list all adverse events Member experienced following each dose:
  ____________________________________________.

- Has the Member shown a demonstrated response to Spinraza treatment by showing a significant clinical improvement documented using quantitative scores using the same motor function test(s) used prior to initiating Spinraza treatment? Yes ___ No___

- Was the improvement of SMA related symptoms compared to the baseline assessment and was motor function measured against the degenerative effects of SMA? Yes ___ No___
✓ Did a provider other than the one who initially performed the motor exam complete any follow-up exam(s)? Yes ___ No___

✓ Did the Member’s clinical improvement include, at a minimum, the following?
  ➢ At least a two (2) point increase in ability to kick or a one (1) point increase in head control, rolling, sitting, crawling, standing, or walking in HINE-2? Yes ___ No___ N/A___
  ➢ At least a three (3) point increase in HFMSE? Yes ___ No___ N/A___
  ➢ At least a two (2) point increase in ULM? Yes ___ No___ N/A___

✓ Has the Member remained free of permanent ventilation (16 hours or greater per 24 hours) since onset of Spinraza treatment? Yes ___ No___

✓ Has the Member’s required any additional respiratory support since the onset of Spinraza treatment? Yes ___ No___

✓ Describe all changes to the Member’s respiratory status since the onset of Spinraza treatment:
  __________________________________________________________________________________________
  __________________________________________________________________________________________
  __________________________________________________________________________________________

Please include additional pertinent clinical information below:
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