Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health

Nusinersen (Spinraza) – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

Diagnosis Information: (please indicate the diagnosis and answer the related questions)

□ Spinal Muscular Atrophy (SMA)
- Please send in medical records (such as genetic testing, labs) confirming 5q SMA homozygous gene mutation, homozygous gene deletion, or compound heterozygote.
- If the member has Spinal Muscular Atrophy, please provide which type of SMA the member has : _____

□ Other, please specify _____

General Questions:

1. Is the medication prescribed by or in consultation with a pediatric/adult neurologist or a physician who is an expert in neuromuscular disorders?

□ Yes □ No _____

2. Will lab testing for platelet counts be completed at baseline and prior to each dose ? **Yes or No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health

Nusinersen (Spinraza) – Medical Necessity Request

****Complete page 2 only for Subsequent/Renewal requests****

Diagnosis Information: (please indicate diagnosis and answer related questions):

□ Spinal Muscular Atrophy (SMA)

□ Other, please specify _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**