Spinraza

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **HPHC Provider ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Criteria Questions:

1. What is the diagnosis? ❑ Spinal muscular atrophy ❑ Other _____
2. What is the ICD-10 code? _____
3. Has the patient previously received Spinraza? *If Yes, skip to #8* ❑ Yes ❑ No
4. Which type of spinal muscular atrophy does the patient have?
   ❑ Type 0 ❑ Type 1 ❑ Type 2
   ❑ Type 3 ❑ Type 4 ❑ Unknown
5. Is the prescription for Spinraza submitted by or in consultation with a board eligible/certified neurologist?
   ❑ Yes ❑ No
6. Does the patient have at least two copies of the SMN2 gene? ***If yes, please attach supporting documentation (e.g., genetic testing showing at least two copies of the SMN2 gene).*** ❑ Yes ❑ No

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-844-387-1435 ● Fax: 1-844-851-0882 ● www.caremark.com

7. Will the initial dose of Spinraza be administered within the same week as, preferably immediately subsequent to, a Hammersmith Infant Neurological Exam (HINE), Hammersmith Functional Motor Scale, Expanded (HFMSE) assessment Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), or Upper Limb Module (ULM), non-ambulatory, test? ❑ Yes ❑ No *No further questions.*

8. Is the patient demonstrating significant improvement in SMA associated symptoms from pretreatment baseline status (as measured within the same week as Spinraza initiation) through ANY of the following?
If yes, please attach supporting documentation (e.g., medical records).
    - An increase or maintenance of previous increase of at least two points from pretreatment baseline on the HFMSE, OR
    - A cumulative change of at least positive one point in all HINE section 2 categories but voluntary grasp from pretreatment baseline, OR
    - An increase or maintenance of previous increase of at least two points from pretreatment baseline on the INTEND-CHOP,OR
    - Comorbidities or injuries that would have made the member's current HFMSE/HINE/INTEND-CHOP/ULM results unexpected without Spinraza treatment.

    ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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