



Nevada Medicaid Spinraza® Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Molina ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:		State:	Zip:	Office Street Address:	
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>	
Select the diagnosis below:	
<input type="checkbox"/> Spinal muscular atrophy (SMA)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
Is Spinraza® prescribed by or in consultation with a neurologist who has experience treating SMA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reauthorization:	
If this is a reauthorization request, also answer the following questions	
Is the recipient maintaining neurological status? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the recipient tolerating therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the recipient been on therapy for 12 months or more? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes" to the above question, has the recipient experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Spinraza_NevadaMedicaid_2019May-W

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