Clinical Criteria Worksheet: (Nusinersen Spinraza®)

Claim Submission

Enrollee Information

- Claim processing may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
- A claim should not be submitted until the drug has been administered to the patient.
- The manufacturer invoice showing the acquisition cost of the drug administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the drug, or it will be rejected for not enough documentation.

Enrollee Last Name:	Enrollee First Name:									
Date of Birth (MM/DD/YYYY):	Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):									
/ / / /										
Address:										
City, Town or Post Office:	State: ZIP Code:									
Prescriber Information										
Prescriber Last Name:	Prescriber First Name:									
National Provider Identifier (NPI) Number:										
Preferred Contact (Telephone Number)										

Enro	llee	Last	Name:									Enroll	ee Firs	t Na	me:							
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Cli	nica	l Cr	iteria																			
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Attestation	Enrollee Last Name:	Enrollee Fi	rst Name:				
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I attest that this drug is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical							
necessity is available for review if requested by the New York State Medicaid Program.							

Date (MM/DD/YYYY)

Prescriber Signature (Required)