

Enrollee Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Enrollee First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Clinical Criteria – Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Clinical Criteria – Diagnosis

1. Does the patient have a diagnosis of spinal muscular atrophy (SMA)?

Yes No

Clinical Criteria

2. Please indicate if this request is for the initiation or continuation of nusinersen therapy?

Initiation Continuation

3. Is the patient using both Spinraza® (nusinersen) and Evrysdi® (risdiplam) concurrently?

Yes No

4. Has the patient ever received abeparvovec-xioi (Zolgensma®)?

Yes No

5. Does the patient have advanced disease (e.g. complete limb paralysis or permanent ventilation dependence)?

Yes No

Enrollee Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Enrollee First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Archived December 2024

Attestation

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.

Prescriber Signature (Required)

Date (MM/DD/YYYY)