Clinical Criteria Worksheet:
Spinraza® (nusinersen)

Enrollee Information

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): _____

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

Enrollee Last Name: **Enrollee First Name:**

_____ _____

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

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)**