Spinraza

HMSA Medicare Advantage - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Patient's Phone Number: ________________________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

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

Additional Demographic Information:

Patient Weight: __________________________*kg*

Patient Height: ____________*ft* ___________*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient hospital ❑ Office
❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? ________________

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Spinraza HMSAMED C26863-A – 03/2025.

Criteria Questions:

1. What is the diagnosis?

❒ Spinal muscular atrophy, *Continue to #2*

❒ Other, *Continue to #2*

2. Is this a request for initial therapy or for continuation of therapy?

❒ Initial therapy with Spinraza, *Continue to #4*

❒ Continuation therapy with Spinraza, *Continue to #3*

3. Is the member receiving benefit from Spinraza therapy?

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

4. Was the diagnosis of spinal muscular atrophy confirmed by genetic testing showing a deletion or mutation in the SMN1 allele? If yes, supporting documentation of genetic testing showing deletion or mutation in the SMN1 allele must be available upon request

❒ Yes, *Continue to #5*

❒ No, *Continue to #5*

5. Which type of spinal muscular atrophy does the patient have?

❒ Type 0, *Continue to #6*

❒ Type 1, *Continue to #6*

❒ Type 2, *Continue to #6*

❒ Type 3, *Continue to #6*

❒ Type 4, *Continue to #6*

❒ Unknown, *Continue to #6*

6. Will the requested drug be used concomitantly with Evrysdi?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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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CVS Caremark Specialty Programs ● 2969 Mapunapuna Place ● Honolulu, HI 96819

Phone: 1-808-254-4414 ● Fax: 1-866-237-5512 ● www.caremark.com