Clinical Criteria Worksheet:
(Nusinersen Spinraza®)

Claim Submission

- 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 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)

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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:

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)