Specialty Prescription Order Form

Spinraza® (nusinersen) injection, for intrathecal use

accredo®

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name _____
Last name _____ Middle initial _____
Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____
Street address _____ Apt # _____
City _____ State _____ Zip _____
Parent/guardian (if applicable) _____
Home phone _____ Work phone _____ Cell phone _____
Evening phone _____ E-mail address _____
Patient's primary language: ❑ English ❑ Other If other, please specify _____
If this order is for a pre-natally diagnosed infant, please include:
Mother's name _____
Last 4 of Mother's SSN _____ **Expected infant delivery date** _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____
Phone _____
Insured's name _____
Insured's employer _____ Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card: ❑ Yes ❑ No If yes, carrier _____
Policy # _____ Group # _____
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
Prescriber's first name _____ Last name _____
Prescriber's title _____
If NP or PA, under direction of Dr. _____
Office contact and title _____
Office contact email _____
Office/clinic/institution name _____
Clinic/hospital affiliation _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
Deliver product to: ❑ Hospital ❑ Clinic
Shipping address _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____ Date of Dx _____
SMA Type: ❑ I ❑ II ❑ III ❑ Other _____
Is diagnosis confirmed by genetic testing? ❑ Yes ❑ No
If yes, please include copies of all available results of genetic analysis.
Plan authorization may require one or more of the following: (please attach if available)
· Genetic confirmation of SMN-1 deletion or mutation status
· Documented parental carrier status or prenatal testing
· Documented family history of 5qSMA
· SMN-2 genetic analysis
· Chart note indicating patient status or response to therapy
SCr _____ Date _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Spinraza (nusinersen)	12mg/5mL vial	Administer 12mg intrathecally via sterile procedure as per product instructions according to the following schedule (enter dates to be given): ❑ Loading dose 1: _____ ❑ Already given in hospital/clinic ❑ Loading dose 2 (14 days after loading dose 1): _____ ❑ Already given in hospital/clinic ❑ Loading dose 3 (14 days after loading dose 2): _____ ❑ Already given in hospital/clinic ❑ Loading dose 4 (30 days after loading dose 3): _____ ❑ Already given in hospital/clinic ❑ **Maintenance dose** given every 4 months after 4th loading dose: Next injection date _____ Other instructions _____	Dispense: ❑ Up to 28 days supply for loading or 1 maintenance administration ❑ Other _____ Refills _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including thesubmission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Dispense as written _____ Date _____ Substitution allowed _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to your team at 808.650.6487. To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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