

Spinraza® (nusinersen) injection, for intrathecal use

Four simple steps to submit your referral.

1 PATIENT INFORMATION

 New patient Current

Patient's name _____
 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 _____
 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 front and back of patient's pharmacy and medical benefit cards and/or financial assistance.

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 name and title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 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
<input type="checkbox"/> Spinraza (nusinersen)	12 mg/5 mL vial	Administer 12 mg intrathecally via sterile procedure as per product instructions according to the following schedule (enter dates to be given): <input type="checkbox"/> Loading dose 1: _____ <input type="checkbox"/> Already given in hospital/clinic <input type="checkbox"/> Loading dose 2 (14 days after loading dose 1): _____ <input type="checkbox"/> Already given in hospital/clinic <input type="checkbox"/> Loading dose 3 (14 days after loading dose 2): _____ <input type="checkbox"/> Already given in hospital/clinic <input type="checkbox"/> Loading dose 4 (30 days after loading dose 3): _____ <input type="checkbox"/> Already given in hospital/clinic <input type="checkbox"/> Maintenance dose given every 4 months after 4 th loading dose: Next injection date _____ Other instructions _____ _____ _____	Dispense: <input type="checkbox"/> Up to 28 days supply for loading or 1 maintenance administration <input type="checkbox"/> 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.

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

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

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 866.579.4655.

To reach your team, call toll-free 855.778.1510, option 3 for Accredo Specialty Pharmacy.

You can now track shipments for all your Accredo patients.

Go to <https://prescribers.accredo.com> and click "Help" to register.