Pharmacy Drug Policy Checklist

POLICY NAME	Spinraza (nusinersen)	POLICY #	2609P

Criteria

Coverage Criteria

- ☐ **1.1** Diagnosis of Spinal Muscular Atrophy (SMA) types I, II, or III
- ☐ **1.2** Documentation of 5q SMA homozygous gene mutation, homozygous gene deletion, or compound heterozygote
- ☐ **1.3** Ordered by a Geneticist or provider specializing in the treatment of SMA
- ☐ **1.4** Member is 15 years of age or younger at initiation of treatment
- ☐ **1.5** Documented baseline motor milestone scores according to one of the following age-appropriate assessments:
  - Hammersmith Infant Neurologic Exam (HINE)
  - Modified Hammersmith Functional Motor-Scale
  - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP –INTEND)
  - Bayley Scales of Infant and Toddler Development (BSID-III)
  - Motor Function Measure 32 (MFM-32)
- ☐ **1.6** Review of chart notes and labs documenting diagnosis and confirming that patient has met all of the above requirements for treatment with Spinraza by both a pharmacist and medical director

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Spinraza will not be covered after treatment with Zolgensma because its use following Zolgensma infusion has not been studied and is considered experimental/investigational
  - Note: Patients in the clinical trials that received Zolgensma before the age of 2 were followed up to 5 years post-treatment and did not require additional medications
- ☐ **2.2** Spinraza will not be covered in combination with Evrysdi because the concomitant use of these two drugs has not been studied and is considered experimental/investigational