

# BLUE CROSS BLUE SHIELD

Federal Employee Program

## PRIOR AUTHORIZATION REQUEST FORM

Date of Request:

02/01/2026

Request ID:

PA2026797894

### SECTION 1: MEMBER INFORMATION

|                   |   |               |  |            |              |
|-------------------|---|---------------|--|------------|--------------|
| Member Last Name: | WILLIAMS                                      | First Name:   | ETHAN  | MI:        |              |
| Date of Birth:    | 2025-06-10                                    | Gender:       | <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male | Phone:     | 312-555-0467 |
| Member ID:        | FEP567891234                                  | Group Number: | FEP-FAMILY-2025  | Plan Type: | PPO          |
| Address:          | 1456 North Lakeshore Drive, Chicago, IL 60610 |               |  |            |              |

**Parent/Guardian:** Michael and Jennifer Williams (Parents) | Phone: 312-555-0467

**Subscriber:** Michael Williams

### SECTION 2: PRESCRIBER/FACILITY INFORMATION

|                  |  |
|------------------|--|
| Prescriber Name: | Dr. Anna Kowalski, MD, PhD                           |
| Specialty:       | Pediatric Neurology (Neuromuscular Disorders)        |
| Practice Name:   | Ann & Robert H. Lurie Children's Hospital of Chicago |
| NPI:             | 1654789321   |
| Address:         | 225 East Chicago Avenue, Chicago, IL 60611           |
| Phone:           | 312-555-0800   |
| Fax:             | 312-555-0801   |

### SECTION 3: MEDICATION/SERVICE REQUESTED

|                            |   |
|----------------------------|---|
| Drug Name (Brand/Generic): | Spinraza (Nusinersen)   |
| NDC / J-Code / HCPCS:      | J2326   |
| Strength / Dose:           | 12 mg (5 mL) per intrathecal injection                                      |
| Route of Administration:   | Intrathecal injection   |
| Frequency:                 | Loading: Day 0, Day 14, Day 28, Day 63; Maintenance: Once every 4 months    |
| Duration of Therapy:       | 12 months initial authorization (4 loading + 2 maintenance doses)           |
| Quantity Requested:        | 6 doses   |
| Site of Service:           | Pediatric hospital — intrathecal administration under fluoroscopic guidance |
| Requested Start Date:      | 2026-03-01  |

### SECTION 4: DIAGNOSIS INFORMATION

|         | ICD-10 Code | Diagnosis Description                                       |
|---------|-------------|---|
| Primary | G12.0       | Infantile spinal muscular atrophy, type I [Werdnig-Hoffman] |

### SECTION 5: PRIOR TREATMENT HISTORY / STEP THERAPY

No prior systemic therapy — de novo presentation.

### SECTION 6: CLINICAL INFORMATION / MEDICAL NECESSITY

Ethan Williams is a 7-month-old male — Progressive generalized hypotonia and motor regression in 7-month-old male with genetically confirmed SMA Type 1

7-month-old male born full-term with normal birth history. Parents noted poor head control and generalized hypotonia at 3 months of age. Referred to pediatric neurology at 4 months. EMG showed diffuse denervation pattern consistent with anterior horn cell disease. Genetic testing at 5 months confirmed SMA Type 1 (homozygous SMN1 deletion, 3 SMN2 copies). Progressive motor decline with loss of previously acquired limb movements. Currently unable to sit independently, poor head control, weak cry, feeding difficulties requiring intermittent NG supplementation. No prior gene therapy (Zolgensma) or antisense oligonucleotide therapy.

**Disease Activity:** Sma Type: Type 1

## SECTION 7: PRESCRIBER ATTESTATION

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I attest that the requested medication/service is medically necessary for this patient. I understand that payment of claims will be from Federal and/or State funds, and that any false claims, statements, or documents may be prosecuted under applicable Federal and State laws.

**Prescriber Signature:** \_\_\_\_\_

**Date Signed:** 02/01/2026

**Print Name:**

DR. ANNA KOWALSKI

**NPI:**

1654789321

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SUBMIT TO: BCBS FEP Prior Authorization Department | Fax: 1-800-XXX-XXXX | Portal: provider.bcbs.com  
Standard Review: 5 business days | Expedited Review: 72 hours | Effective: 01/2026 | Form Version 10.1