

BLUE CROSS BLUE SHIELD

Federal Employee Program

PRIOR AUTHORIZATION REQUEST FORM

Date of Request:	02/01/2026	Request ID:	PA2026797894
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SECTION 1: MEMBER INFORMATION

Member Last Name:	WILLIAMS	First Name:	ETHAN	MI:	
Date of Birth:	2025-06-10	Gender:	■ Female ■ 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

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