SPINRAZA®
(nusinersen) injection 12 mg/5 mL

SPINRAZA BENEFITS INVESTIGATION WORKSHEET

A Benefits Investigation is a process that enables a practice or facility to determine benefit design, coverage requirements, coding guidance, and drug acquisition options for a specific patient before administering treatment. For SPINRAZA, your practice or facility will need to know how the patient's health plan covers both the drug component and the administration component. Note that SPINRAZA will most often be covered under the health plan's medical benefit.

It is important to determine each patient's level of coverage before each administration of SPINRAZA because health plan coverage can vary and change over time.

As you conduct the Benefits Investigation, this worksheet can assist you in information gathering while engaging a patient's health plan. In this guide, you will find

- A sample Benefits Investigation Worksheet with instructions, which explains the type of information that needs to be captured in each field
- An editable Benefits Investigation Worksheet. This form, which has fields that can be typed in, can be printed for a patient's file. You can also print the form first and write in the information

BENEFITS INVESTIGATION WORKSHEET—INSTRUCTIONS

Step 1: OBTAIN BASIC PATIENT INFORMATION. Gather this information before calling the health plan.

Patient Name: _____ Date of Birth: ____/____/_____ Policyholder Name: _____

Health Plan Name: _____ Phone Number: _____

Member #: _____ Group #: _____ Plan Type: ☐ HMO ☐ PPO ☐ POS ☐ Other _____

Health Plan: ☐ Primary ☐ Secondary ☐ Tertiary Is There a Secondary Policy: ☐ Yes ☐ No In Network: ☐ Yes ☐ No

Physician Name/Practice or Facility: _____ Tax ID: _____ Provider #: _____

Step 2: CONTACT PATIENT'S HEALTH PLAN.

Ask to speak to a case manager or neuromuscular specialist. Capture the details below for easier follow-up. Complete this information as early as possible before SPINRAZA administration.

Researched Date: ____/____/____ Time: _____ Person(s) You Spoke With: _____

Policy Year Is: ☐ Calendar ☐ Benefit Effective Date: ____/____/_____ Termination Date: ____/____/_____

ICD Code[a]: **G12.0 or G12.1** NDC Code[a]: **64406-0058-01** HCPCS Code[a]: **J2326** Procedure Code(s)[a]: _____

Billing Preference: _____

Step 3: DETERMINE PROCUREMENT AND PATIENT COVERAGE.

SPINRAZA can be obtained either by placing an order through CuraScript Specialty Distributor (SD) or by submitting a prescription to Accredo Specialty Pharmacy (SP). It is up to your institution to determine the procurement option that works best for your practice or facility. The patient's health plan may also require a specific procurement option.

	ADMINISTRATION	DRUG		
	Administration Through Major Medical Benefit (The practice or facility bills for the infusion/injection and receives reimbursement from the health plan)	**Practice or Facility Purchase Option Through Major Medical Benefit** (The practice or facility purchases treatment, bills for the drug, and receives reimbursement from the health plan)	**Specialty Pharmacy Option Through Major Medical Benefit** (Benefits are assigned to a network specialty pharmacy. The specialty pharmacy bills for the cost of treatment)	**Specialty Pharmacy Option Through Prescription Drug Benefit** (Treatment is covered under the pharmacy benefit. The specialty pharmacy bills for the cost of treatment)
Outcome:	☐ Covered ☐ Not Covered	☐ Covered ☐ Not Covered	☐ Covered ☐ Not Covered	☐ Covered ☐ Not Covered
Drug covered:	–	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Deductible:	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **pharmacy benefit**: $
Deductible met:	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **pharmacy benefit**: $
Out-of-pocket maximum:	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **pharmacy benefit**: $
Out-of-pocket maximum met:	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **major medical benefit**: $	Enter amount that applies to **pharmacy benefit**: $
Accredo Specialty Pharmacy (SP)	–	–	Name: Phone #:	Name: Phone #:
Coinsurance or copay:	Enter % **or** $ amount that applies to **major medical benefit**	Enter % **or** $ amount that applies to **major medical benefit**	Enter % **or** $ amount that applies to **major medical benefit**	Enter % **or** $ amount that applies to **pharmacy benefit**
Additional benefit information:	Enter any important details here	Enter any important details here	Enter any important details here	Enter any important details here

[a]For detailed information about coding for SPINRAZA (including procedure codes), refer to the **Relevant Code and Sample Claim Form Guide**, available at **spinraza-hcp.com**.

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BENEFITS INVESTIGATION WORKSHEET—INSTRUCTIONS

Step 4: DETERMINE IF THE PATIENT REQUIRES SPECIAL PRECLEARANCE BEFORE BEING COVERED FOR TREATMENT.

	ADMINISTRATION	DRUG		
	Administration Through Major Medical Benefit	**Practice or Facility Purchase Option Through Major Medical Benefit**	**Specialty Pharmacy Option Through Major Medical Benefit**	**Specialty Pharmacy Option Through Prescription Drug Benefit**
Prior authorization (PA)/ Predetermination (Pre-D) required?	N/A	Enter if there is a PA or other Pre-D requirement here	Enter if there is a PA or other Pre-D requirement here	Enter if there is a PA or other Pre-D requirement here
Required documentation:	–	Enter required PA or Pre-D documentation that must be submitted to the health plan here	Enter required PA or Pre-D documentation that must be submitted to the health plan here	Enter required PA or Pre-D documentation that must be submitted to the health plan here
Required criteria:	–	Enter required PA or Pre-D criteria here	Enter required PA or Pre-D criteria here	Enter required PA or Pre-D criteria here
Attention to:	–			
Phone:	–			
Fax:	–			
PA status:	–	Track the status of your PA here	Track the status of your PA here	Track the status of your PA here
PA expiration date:	–	Track the PA expiration here	Track the PA expiration here	Track the PA expiration here
PA instructions:	–	Record any special PA instructions here	Record any special PA instructions here	Record any special PA instructions here

Step 5: RECORD ANY SPECIAL INSTRUCTIONS HERE.

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BENEFITS INVESTIGATION WORKSHEET—EDITABLE FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/____/_____ Policyholder Name: _____

Health Plan Name: _____ Phone Number: _____

Member #: _____ Group #: _____ Plan Type: ☐ HMO ☐ PPO ☐ POS ☐ Other _____

Health Plan: ☐ Primary ☐ Secondary ☐ Tertiary Is There a Secondary Policy: ☐ Yes ☐ No In Network: ☐ Yes ☐ No

Physician Name/Practice or Facility: _____ Tax ID: _____ Provider #: _____

CALL DETAILS

Researched Date: ____/____/____ Time: _____ Person(s) You Spoke With: _____

Policy Year Is: ☐ Calendar ☐ Benefit Effective Date: ____/____/_____ Termination Date: ____/____/_____

ICD Code[a]: _____ NDC Code[a]: _____ HCPCS Code[a]: _____ Procedure Code(s)[a]: _____

Billing Preference: _____

PATIENT BENEFIT OPTIONS

	ADMINISTRATION	DRUG		
	Administration Through Major Medical Benefit (The practice or facility bills for the infusion/injection and receives reimbursement from the health plan)	**Practice or Facility Purchase Option Through Major Medical Benefit** (The practice or facility purchases treatment, bills for the drug, and receives reimbursement from the health plan)	**Specialty Pharmacy Option Through Major Medical Benefit** (Benefits are assigned to a network specialty pharmacy. The specialty pharmacy bills for the cost of treatment)	**Specialty Pharmacy Option Through Prescription Drug Benefit** (Treatment is covered under the pharmacy benefit. The specialty pharmacy bills for the cost of treatment)
Outcome:	☐ Covered ☐ Not Covered	☐ Covered ☐ Not Covered	☐ Covered ☐ Not Covered	☐ Covered ☐ Not Covered
Drug covered:	–	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Deductible:	$	$	$	$
Deductible met:	$	$	$	$
Out-of-pocket maximum:	$	$	$	$
Out-of-pocket maximum met:	$	$	$	$
Accredo Specialty Pharmacy (SP)	–	–	Name: Phone #:	Name: Phone #:
Coinsurance or copay:	% **or** $	% **or** $	% **or** $	% **or** $
Additional benefit information:				

[a]For detailed information about coding for SPINRAZA (including procedure codes), refer to the **Relevant Code and Sample Claim Form Guide**, available at **spinraza-hcp.com**.

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BENEFITS INVESTIGATION WORKSHEET—EDITABLE FORM

SPECIAL PRECLEARANCE

	ADMINISTRATION	DRUG		
	Administration Through Major Medical Benefit	Practice or Facility Purchase Option Through Major Medical Benefit	Specialty Pharmacy Option Through Major Medical Benefit	Specialty Pharmacy Option Through Prescription Drug Benefit
Prior authorization (PA)/ Predetermination (Pre-D) required?				
Required documentation:	–			
Required criteria:	–			
Attention to:	–			
Phone:	–			
Fax:	–			
PA status:	–			
PA expiration date:	–			
PA instructions:	–			

SPECIAL INSTRUCTIONS

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