Nusinersen (SPINRAZA) for Spinal Muscular Atrophy (SMA) [3444]

Ordering Restrictions for Nusinersen (Spinraza™):
1. Nusinersen (Spinraza™) is restricted to Neurology specialists.
2. Nusinersen (Spinraza™) is restricted to patients with prior financial approval.

Nursing

NURSING ORDERS NUSINERSEN

[ ]	Bed rest	Routine, Until discontinued, Starting S Bathroom Privileges: As needed for headache
[ ]	Notify Physician (NUSINERSEN monitoring)	Routine, Until discontinued, Starting S, If headache is severe and not resolved with bed rest and acetaminophen
[ ]	Other	

Medications

Monitoring

[ ]	Monitoring Medications	
[ ]	acetaminophen (TYLENOL) tablet	500 mg, oral, every 6 hours PRN, headaches
[ ]	Other	

Loading Dose Treatment Schedule (Single Response)

Please select the appropriate Treatment Day

( )	Treatment Day 1	

[ ]	nusinersen (PF) intrathecal solution for Spinal Muscular Atrophy - Treatment Day 1	12 mg, intrathecal, once, For 1 Doses
		Administer once on Treatment Day 1
		RESTRICTED to Neurology specialists. Are you a Neurology specialist or ordering on behalf of one?
		if (answer = YES, I am ordering on behalf of an approved provider)
		Name of Approved Provider:
		if (answer = NO)
		HM Policy Alert:
		if (answer = Formulary policy override (pharmacist use only))
		Provide name of secondary pharmacist who provided authorization and open a “Formulary Policy Override” i-Vent:
		RESTRICTED to patients with prior financial approval. Do you attest that the patient’s insurance has given financial approval for the administration of Nusinersen (Spinraza™)?

( )	Treatment Day 15	

[ ] nusinersen (PF) intrathecal solution for Spinal Muscular Atrophy - Treatment Day 15	12 mg, intrathecal, once, For 1 Doses
	Administer once on Treatment Day 15
	RESTRICTED to Neurology specialists. Are you a Neurology specialist or ordering on behalf of one?
	if (answer = YES, I am ordering on behalf of an approved provider)
	Name of Approved Provider:
	if (answer = NO)
	HM Policy Alert:
	if (answer = Formulary policy override (pharmacist use only))
	Provide name of secondary pharmacist who provided authorization and open a “Formulary Policy Override” i-Vent:
	RESTRICTED to patients with prior financial approval. Do you attest that the patient’s insurance has given financial approval for the administration of Nusinersen (Spinraza™)?
	Please enter the DATE that last dose was received:

( ) Treatment Day 29	**"Followed by" Linked Panel**

[ ] nusinersen (PF) intrathecal solution for Spinal Muscular Atrophy - Treatment Day 29	12 mg, intrathecal, once, For 1 Doses
	Administer once on Treatment Day 29
	RESTRICTED to Neurology specialists. Are you a Neurology specialist or ordering on behalf of one?
	if (answer = YES, I am ordering on behalf of an approved provider)
	Name of Approved Provider:
	if (answer = NO)
	HM Policy Alert:
	if (answer = Formulary policy override (pharmacist use only))
	Provide name of secondary pharmacist who provided authorization and open a “Formulary Policy Override” i-Vent:
	RESTRICTED to patients with prior financial approval. Do you attest that the patient’s insurance has given financial approval for the administration of Nusinersen (Spinraza™)?
	Please enter the DATE that last dose was received:

( ) Treatment Day 59	

[ ] nusinersen (PF) intrathecal solution for Spinal Muscular Atrophy - Treatment Day 59	12 mg, intrathecal, once, For 1 Doses
	Administer once on Treatment Day 59
	RESTRICTED to Neurology specialists. Are you a Neurology specialist or ordering on behalf of one?
	if (answer = YES, I am ordering on behalf of an approved provider)
	Name of Approved Provider:
	if (answer = NO)
	HM Policy Alert:
	if (answer = Formulary policy override (pharmacist use only))
	Provide name of secondary pharmacist who provided authorization and open a “Formulary Policy Override” i-Vent:
	RESTRICTED to patients with prior financial approval. Do you attest that the patient’s insurance has given financial approval for the administration of Nusinersen (Spinraza™)?
	Please enter the DATE that last dose was received:

[ ] Other	

Maintenance Doses

[ ]	nusinersen (SPINRAZA) Maintenance Doses for Spinal Muscular Atrophy	**"Followed by" Linked Panel**
[ ]	nusinersen (PF) intrathecal solution for Spinal Muscular Atrophy	12 mg, intrathecal, once, For 1 Doses Administer once every 4 months Please enter the DATE that last dose was received:
[ ]	Other	

Labs

LABS

[ ]	CBC hemogram	Once For 1 Occurrences Obtain at baseline and prior to each dose
[ ]	Prothrombin time with INR	Once For 1 Occurrences Obtain at baseline and prior to each dose.
[ ]	Partial thromboplastin time, activated	Once For 1 Occurrences Obtain at baseline and prior to each dose.
[ ]	Protein, urine, random	Once For 1 Occurrences Obtain at baseline and prior to each dose.
[ ]	Other	