Spinraza *(nusinersen sodium)*

PA Criteria	Criteria Details
Covered Uses (FDA approved indication)	Spinraza intrathecal injection is a survival motor neuron-2 (SMN2)-directed antisense oligonucleotide indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients.
Exclusion Criteria	None.
Required Medical Information	For initial requests: Confirmation of spinal muscular atrophy (SMA) by genetic testing.
Age Restriction	None.
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	Two years. Dose will be approved according to the FDA-approved labeling or within accepted standards of medical practice.
Other Criteria/Information	Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document.

HCPCS	Description	Billing Units/How Supplied
J2326	Spinraza (nusinersen sodium)	**Billing unit: 0.1 mg** 12 mg/5 mL SDV

STATUS	DATE REVISED	REVIEW DATE	APPROVED/REVIEWED BY	EFFECTIVE DATE
Created	3/26/2025	3/26/2025	Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG)	N/A
Approved	N/A	8/21/2025	Pharmacy & Therapeutics (P&T) Committee	8/21/2025