Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Adbry 150 mg/mL subcutaneous syringe
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year))

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Moderate to severe atopic dermatitis

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: Does the member have documentation supporting positive clinical response to therapy as evidenced by at least one of the following: (Check only one that apply)

[ ] Reduction in BSA involvement from baseline (please provide documentation(s) supporting the positive response to the therapy) _____(*Required)

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

[ ] Reduction in SCORAD index value from baseline (please provide documentation(s) supporting the positive response of the therapy) _____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Moderate to severe atopic dermatitis

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q6: Does the member have one of the following: (Check only one that apply)

[ ] Involvement of at least 10% body surface area (BSA) _____ (*Required)

[ ] SCORing Atopic Dermatitis (SCORAD) index value of at least 25 _____(*Required)

[ ] None of the above (please provide clinical rationale for the request) _____(*Required)

Q7: Is the member 18 years of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age and provide clinical rationale for the request) _____(*Required)

Q8: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to medium or higher potency topical corticosteroid? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q9: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to pimecrolimus cream? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q10: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to tacrolimus ointment? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q11: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to Eucrisa (crisaborole) ointment? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q12: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to medium or higher potency topical corticosteroid? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q13: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to pimecrolimus cream? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q14: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to tacrolimus ointment? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q15: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to medium or higher potency topical corticosteroid? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q16: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to pimecrolimus cream? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q17: Has the member had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to medium or higher potency topical corticosteroid? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No _____(*Required)

Q18: Is the medication prescribed by or in consultation with a dermatologist or allergist/immunologist? (Check only one that apply)

[ ] Yes (please specify the prescriber's specialty) _____(*Required)

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[ ] No (please provide clinical rationale for the request) _____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	