

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): | <input type="checkbox"/> Alunbrig 180 mg tablet <input type="checkbox"/> Alunbrig 30 mg tablet <input type="checkbox"/> Alunbrig 90 mg (7)-180 mg (23) tablets in a dose pack <input type="checkbox"/> Alunbrig 90 mg tablet |
| Requested Daily Quantity Limit – Amount: | |
| Requested Daily Quantity Limit – Days: | |
| Requested Quantity Limit Over Time – Amount: | |
| Requested Quantity Limit Over Time – 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)) _____
(*Required)

No

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

Metastatic non-small cell lung cancer (NSCLC)

Other (please specify the member's diagnosis and provide clinical rationale for the request)

_____ (*Required)

Q4: What is the member's diagnosis? (Check only one that apply)

Metastatic non-small cell lung cancer (NSCLC)

Other (please specify the member's diagnosis and provide clinical rationale for the request)

_____ (*Required)

Q5: Does the member have an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)? (Check only one that apply)

Yes (please provide the date of test, name of the test, name of the laboratory, and test results)

_____ (*Required)

No (please provide clinical rationale for the request) _____

(*Required)

Q6: Is the requested medication prescribed by or in consultation with an oncologist? (Check only one that apply)

Yes

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: