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):	[ ] Ayvakit 100 mg tablet [ ] Ayvakit 200 mg tablet [ ] Ayvakit 25 mg tablet [ ] Ayvakit 300 mg tablet [ ] Ayvakit 50 mg tablet
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)

[ ] Unresectable or metastatic gastrointestinal stromal tumor (GIST)

[ ] Advanced Systemic Mastocytosis (AdvSM)

[ ] 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)

[ ] Unresectable or metastatic gastrointestinal stromal tumor (GIST)
_____(*Required)

[ ] Advanced Systemic Mastocytosis (AdvSM)

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

Q5: Does the member have a diagnosis with the presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations? (Check only one that apply)

[ ] Yes (please specify the date(s) of test and test result(s)) _____
(*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)

Q7: Does the member have any one of the following diagnosis related to Advanced Systemic Mastocytosis (AdvSM): (Check only one that apply)

[ ] Aggressive systemic mastocytosis (ASM) _____(*Required)

[ ] Systemic mastocytosis with an associated hematological neoplasm (SM-AHN)
_____(*Required)

[ ] Mast cell leukemia (MCL) _____(*Required)

[ ] Other (please provide clinical rationale for the request) _____
(*Required)

Q8: Is the requested medication prescribed by or in consultation with an oncologist/hematologist, allergist, or immunologist? (Check only one that apply)

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

[ ] 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:	