

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"/> Balversa 3 mg tablet <input type="checkbox"/> Balversa 4 mg tablet <input type="checkbox"/> Balversa 5 mg tablet
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
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)

Prior Authorization Form



No

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

Urothelial Carcinoma

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)

Urothelial Carcinoma

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

_____ (*Required)

Q5: Does the member meets one of the following? (Check only one that apply)

Locally advanced

Metastatic

Other (please provide clinical rationale for the request)

(*Required)

Q6: Does the member has fibroblast growth factor receptor (FGFR) 3 or FGFR2 genetic alterations as detected by an U.S. Food and Drug Administration (FDA)-approved test (therascreen FGFR RGQ RT-PCR Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)? (Check only one that apply)

Yes (please specify type of genetic alterations and diagnostic test performed)

_____ (*Required)

No (please provide clinical rationale for the request)

(*Required)

Q7: Has the member progressed during or following at least one line of prior platinum-containing chemotherapy (e.g., gemcitabine with cisplatin or carboplatin, dose dense methotrexate vinblastine doxorubicin cisplatin [DDMVAC] with growth factor support, etc.)? (Check only one that apply)

Yes (please specify drug name and the start and end date(s) of therapy (month/year))

_____ (*Required)

No

Q8: Has the member progressed within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy (e.g., [DDMVAC] with growth factor support, gemcitabine with cisplatin, etc.)? (Check only one that apply)

Yes (please specify drug name/ growth factor and the start and end date(s) of therapy (month/year))

_____ (*Required)

No (please provide clinical rationale for the request)

(*Required)

Q9: Is the medication prescribed by or in consultation with an oncologist? (Check only one that apply)

Yes

No (please provide clinical rationale for the request)

(*Required)

Prior Authorization Form



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: