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):	[ ] Cablivi 11 mg injection kit [ ] Cablivi 11 mg solution for injection
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: What is the member's diagnosis? (Check only one that apply)

[ ] Acquired thrombotic thrombocytopenic purpura (aTTP)

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

Q3: Will the first dose be (or, was the first dose) administered by a healthcare provider as a bolus intravenous injection? (Check only one that apply)

[ ] Yes (please list start date of first dose (month/day/year)) _____ (*Required)

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

Q4: Will the requested medication be used in combination with immunosuppressive therapy (e.g. rituximab, glucocorticoids)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No (please explain if member is unable to be on immunosuppresive therapy) _____(*Required)

Q5: Will the requested medication be used in combination with plasma exchange? (Check only one that apply)

[ ] Yes

[ ] No

Q6: Has the member completed plasma exchange? (Check only one that apply)

[ ] Yes

[ ] No (please explain) _____(*Required)

Q7: Has it been or will it be 59 days or more have elapsed beyond the last plasma exchange? (Check only one that apply)

[ ] No (please specify number of days) _____(*Required)

[ ] Yes

Q8: Is the requested medication prescribed by or in consultation with a hematologist or oncologist? (Check only one that apply)

[ ] Yes (please provide prescriber speciality) _____(*Required)

[ ] No (please provide prescriber specialty) _____(*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:	