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):	[ ] Carimune NF Nanofiltered 1 gram intravenous solution [ ] Carimune NF Nanofiltered 12 gram intravenous solution [ ] Carimune NF Nanofiltered 3 gram intravenous solution [ ] Carimune NF Nanofiltered 6 gram intravenous solution
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: Does the member have a diagnosis of primary immune deficiency disease? (Check only one that apply)

[ ] Yes

[ ] No

Q3: Is the requested drug administered in the home? (Check only one that apply)

[ ] Yes

[ ] No

Q4: Does the member have provider determination that administration in the home is medically appropriate? (Check only one that apply)

[ ] Yes

[ ] No

Q5: Request is for the treatment of which of following autoimmune mucocutaneous blistering diseases? (Check only one that apply)

[ ] Biopsy-proven pemphigus vulgaris

[ ] None of the above (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

[ ] Pemphigus foliaceus

[ ] Bullous phemphigoid

[ ] Mucous membrane pemphigoid (a.k.a., cicatricial pemphigoid)

[ ] Epidermolysis bullosa acquisita

Q6: Does the member have contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication). Privigen only: Hyperprolinemia. Octagam only: Allergy to corn? (Check only one that apply)

[ ] Yes (please specify drug name and corresponding experienced contraindication(s)) _____(*Required)

[ ] No

Q7: 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

Q8: Is the requested medication prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist)? (Check only one that apply)

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

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

Q9: What is the member's diagnosis? (Check only one that apply)

[ ] Primary Immunodeficiency

[ ] Secondary Acquired Antibody Deficiency

[ ] Hematological Autoimmune Disorders

[ ] Neuromuscular Autoimmune Disorders

[ ] Other Disorders

[ ] None of the above (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q10: Is the request for one of the following? (Check only one that apply)

[ ] Autoimmune blistering disease

[ ] Kawasaki syndrome

[ ] Solid organ transplant

[ ] Non-Oncology renewal(please specify member's diagnosis)
_____(*Required)

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

Q11: Is the request for one of the following? (Check only one that apply)

[ ] Intravenous immunoglobulin (IVIG)

[ ] Subcutaneous immunoglobulin (SCIG)

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

Q12: What is the member's diagnosis? (Check only one that apply)

[ ] Primary Immunodeficiency

[ ] Secondary Acquired Antibody Deficiency

[ ] Hematological Autoimmune Disorders

[ ] Neuromuscular Autoimmune Disorders

[ ] Other Disorders

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

Q13: Is the request for one of the following? (Check only one that apply)

[ ] Common variable immunodeficiency

[ ] Congenital agammaglobulinemia (X-linked or autosomal recessive)

[ ] Severe combined immunodeficiencies

[ ] Wiskott-Aldrich syndrome

[ ] Other Primary Immunodeficiency

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

Q14: Does the member has an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis? (Check only one that apply)

[ ] Yes

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

Q15: Does the member lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine)? (Check only one that apply)

[ ] Yes

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

Q16: Is the request for one of the following? (Check only one that apply)

[ ] B-cell chronic lymphocytic leukemia

[ ] HIV infection

[ ] Multiple myeloma in plateau phase

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

Q17: Does the member have Ig level less than 500 mg/dL? (Check only one that apply)

[ ] Yes

[ ] No

Q18: Does the member have history of recurrent bacterial infections? (Check only one that apply)

[ ] Yes

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

Q19: Does the member have Ig level less than 400 mg/dL? (Check only one that apply)

[ ] Yes

[ ] No

Q20: Does the member have active bleeding or a platelet count less than 10 x 10^9/L? (Check only one that apply)

[ ] Yes

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

Q21: Is the member less than or equal to 12 years old? (Check only one that apply)

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

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

Q22: Does the member have hypogammaglobulinemia? (Check only one that apply)

[ ] Yes

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

Q23: Is the request for one of the following? (Check only one that apply)

[ ] Immunologic acquired (pure) red cell aplasia (PRCA)

[ ] Fetal alloimmune thrombocytopenia

[ ] Hemolytic disease of the newborn

[ ] Idiopathic thrombocytopenic purpura

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

Q24: Does the member have viral PRCA caused by parvovirus B19? (Check only one that apply)

[ ] Yes

[ ] No

Q25: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (i.e., cyclophosphamide, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q26: Does the member have established hyperbilirubinemia? (Check only one that apply)

[ ] Yes

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

Q27: Has the member had an inadequate response, intolerance or experienced contraindication(s) to a 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

Q28: Does the member have platelet count less than 30,000 cells/mm3? (Check only one that apply)

[ ] Yes (please specify member's platelet count) _____(*Required)

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

Q29: Is the request for one of the following? (Check only one that apply)

[ ] Chronic inflammatory demyelinating polyneuropathy

[ ] Guillain-Barre syndrome

[ ] Inflammatory myopathies (dermatomyositis or polymyositis)

[ ] Lambert-Eaton myasthenic syndrome

[ ] Multifocal motor neuropathy

[ ] Myasthenia gravis with severe exacerbations

[ ] Myasthenic crises

[ ] Stiff person syndrome

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

Q30: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (i.e., azathioprine, methotrexate, cyclosporine A, cyclophosphamide, or tacrolimus)? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q31: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (e.g., azathioprine)? (Check only one that apply)

[ ] Yes (please specify 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)

Q32: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (i.e., azathioprine, cyclosporine, cyclophosphamide, or mycophenolate mofetil)? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q33: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least 2 standard therapies (i.e., benzodiazepines, muscle relaxants, or anti-convulsants)? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q34: Is the request for one of the following? (Check only one that apply)

[ ] Autoimmune blistering disease

[ ] Kawasaki syndrome

[ ] Solid organ transplant

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

Q35: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (i.e., azathioprine, cyclosporine, cyclophosphamide, or mycophenolate mofetil)? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q36: Is the request for CMV prophylaxis? (Check only one that apply)

[ ] Yes

[ ] No

Q37: Is the member a kidney transplant recipient? (Check only one that apply)

[ ] Yes

[ ] No

Q38: Does the member have donor specific antibodies? (Check only one that apply)

[ ] Yes

[ ] No

Q39: Does the member have steroid-resistant rejection? (Check only one that apply)

[ ] Yes

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

Q40: Has the member had an inadequate response, intolerance or experienced contraindication(s) to standard therapies? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q41: Is the request for one of the following? (Check only one that apply)

[ ] Gamunex-C

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

[ ] Gammaked

Q42: Is the request for one of the following? (Check only one that apply)

[ ] Common variable immunodeficiency

[ ] Congenital agammaglobulinemia (X-linked or autosomal recessive)

[ ] Severe combined immunodeficiencies

[ ] Wiskott-Aldrich syndrome

[ ] Other Primary immunodeficiency

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

Q43: Does the member has an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis? (Check only one that apply)

[ ] Yes

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

Q44: Does the member lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine)? (Check only one that apply)

[ ] Yes

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

Q45: Has the member had an inadequate response, intolerance or experienced contraindication(s) to a corticosteroid? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q46: Is the requested medication prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist)? (Check only one that apply)

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

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

Q47: Is the requested medication prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist)? (Check only one that apply)

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

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

Q48: Does the member has experienced an objective improvement on immune globulin therapy? (Check only one that apply)

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

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

Q49: Is the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy? (Check only one that apply)

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

[ ] 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:	