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):	[ ] Cholbam 250 mg capsule [ ] Cholbam 50 mg capsule
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)

[ ] No

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

[ ] Bile acid synthesis disorders due to single enzyme defects (BAS)

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

[ ] Peroxisomal disorders (PD)

Q4: Does the member have a documentation of positive clinical response to therapy as evidenced by improvement in liver function (e.g., aspartate aminotransferase [AST], alanine aminotransferase [ALT])? (Check only one that apply)

[ ] Yes (please provide documentation of date of test, liver function parameter(s) and the new decreased value)
_____(*Required)

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

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Bile acid synthesis disorders due to single enzyme defects (BAS)

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

[ ] Peroxisomal disorders (PD)

Q6: Does the member have an abnormal urinary bile acid analysis by mass spectrometry? (Check only one that apply)

[ ] Yes (please specify member's urinary bile acid analysis value)
_____(*Required)

[ ] No

Q7: Does the member have molecular genetic testing consistent with the diagnosis? (Check only one that apply)

[ ] Yes (please specify testing date and results) _____(*Required)

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

Q8: Request will be used as an adjunctive treatment? (Check only one that apply)

[ ] Yes

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

Q9: Does the member have an abnormal urinary bile acid analysis by mass spectrometry? (Check only one that apply)

[ ] Yes (please provide the date and mass spectrometry results)
_____(*Required)

[ ] No

Q10: Does the member have a molecular genetic testing consistent with the diagnosis? (Check only one that apply)

[ ] Yes (please provide the date of test and the genetic testing result)
_____(*Required)

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

Q11: Member exhibits at least one of the following: (Check only one that apply)

[ ] Liver disease (e.g., jaundice, elevated serum transaminases)

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

[ ] Steatorrhea

[ ] Complications from decreased fat-soluble vitamin absorption (e.g., poor growth)

Q12: Is the requested medication prescribed by or in consultation with a hepatologist, medical geneticist, pediatric gastroenterologist, or other specialist that treats inborn errors of metabolism? (Check only one that apply)

[ ] Yes (please specify prescriber 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:	