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):	[ ] Cinryze 500 unit (5 mL) 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: What is the member's diagnosis? (Check only one that apply)

[ ] Prophylaxis of Hereditary angioedema (HAE)

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

Q3: Member's diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by: (Check only one that apply)

[ ] C1-INH antigenic level below the lower limit of normal (please specify C1-INH antigenic levels and date of lab test (month/year)) _____(*Required)

[ ] C1-INH functional level below the lower limit of normal (please specify C1-INH functional levels and date of lab test (month/year)) _____(*Required)

[ ] Other (please explain) _____(*Required)

Q4: Is Cinryze being prescribed for prophylaxis against HAE attacks? (Check only one that apply)

[ ] Yes

[ ] No (please specify indication) _____(*Required)

Q5: Will Cinryze be used in combination with other approved treatments for prophylaxis against HAE attacks? (Check only one that apply)

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

[ ] No

Q6: Is the member 6 years of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age) _____(*Required)

Q7: Is the requested drug prescribed by or in consultation with an immunologist or an allergist? (Check only one that apply)

[ ] Yes (please provide prescriber specialty) _____(*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:	