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):	[ ] Cosentyx Pen 150 mg/mL subcutaneous
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)

[ ] Moderate to severe plaque psoriasis

[ ] Psoriatic Arthritis (PsA)

[ ] Ankylosing Spondylitis (AS)

[ ] Non-radiographic axial spondyloarthritis (nr-axSpA)

[ ] Enthesitis-Related Arthritis (ERA)

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

Q4: Does the member demonstrate positive clinical response to therapy as evidenced by at least one of the following: reduction in the body surface area (BSA) involvement from baseline, or improvement in symptoms (e.g., pruritus, inflammation) from baseline? (Check only one that apply)

[ ] Yes (please explain and attach supporting documentation (such as current chart notes))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy without positive response)
_____(*Required)

Q5: Does the member demonstrate positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline, or reduction in the BSA involvement from baseline? (Check only one that apply)

[ ] Yes (please explain and attach supporting documentation (such as current chart notes))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy without positive response)
_____(*Required)

Q6: Does the member demonstrate positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (e.g., lumbar spine motion, chest expansion), or total active (swollen and tender) joint count? (Check only one that apply)

[ ] Yes (please explain and attach supporting documentation (such as current chart notes))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy without positive response)
_____(*Required)

Q7: Does the member demonstrate positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline? (Check only one that apply)

[ ] Yes (please explain and attach supporting documentation (such as current chart notes))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy without positive response)
_____(*Required)

Q8: What is the member's diagnosis? (Check only one that apply)

[ ] Moderate to severe plaque psoriasis

[ ] Psoriatic Arthritis (PsA)

[ ] Active Ankylosing Spondylitis (AS)

[ ] Active Non-radiographic axial spondyloarthritis (nr-axSpA)

[ ] Active Enthesitis-Related Arthritis (ERA)

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

Q9: Does the member have any of the following? (Check only one that apply)

[ ] At least 3% body surface area (BSA) involvement

[ ] Severe scalp psoriasis

[ ] Palmoplantar (i.e., palms, soles), facial, or genital involvement

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

Q10: Does the member have a minimum 4-week trial and failure duration, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, or coal tar? (Check only one that apply)

[ ] Yes (please specify tried and failed drug and duration of therapy, or, please explain if member cannot try any of the listed drugs) _____(*Required)

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

Q11: Is the medication prescribed by or in consultation with a dermatologist? (Check only one that apply)

[ ] Yes

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

Q12: Does the member have actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement? (Check only one that apply)

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

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

Q13: Is the medication prescribed by or in consultation with a rheumatologist or dermatologist? (Check only one that apply)

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

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

Q14: Does the member have a minimum of one month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen) at maximally tolerated doses? (Check only one that apply)

[ ] Yes (please specify tried and failed drug and duration of therapy, or, please explain if member cannot try any of the listed drugs) _____(*Required)

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

Q15: Does the member have objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)? (Check only one that apply)

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

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

Q16: Does the member have a minimum one month trial and failure duration, contraindication, or intolerance to two nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen) at maximally tolerated doses? (Check only one that apply)

[ ] Yes (please specify tried and failed drugs and duration of therapy for each, or, please explain if member cannot try any of the listed drugs) _____(*Required)

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

Q17: Is the medication prescribed by or in consultation with a rheumatologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide prescriber's 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:	