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):	[ ] Dupixent 100 mg/0.67 mL subcutaneous syringe [ ] Dupixent 200 mg/1.14 mL subcutaneous syringe [ ] Dupixent 300 mg/2 mL subcutaneous syringe
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: 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 atopic dermatitis (AD)

[ ] Moderate to severe eosinophilic asthma (EA)

[ ] Moderate to severe corticosteroid dependent asthma (CDA)

[ ] Chronic rhinosinusitis with nasal polyposis (CRSwNP)

[ ] Eosinophilic esophagitis (EoE)

[ ] Prurigo Nodularis (PN)

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

Q4: Is the member responding positively as evidenced by any one of the following: (Check only one that apply)

[ ] Reduction in BSA involvement from baseline (please specify the reduced BSA involvement)
_____(*Required)

[ ] Reduction in SCORAD index value from baseline (please specify reduced SCORAD index value)
_____(*Required)

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

Q5: Does the member have a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications)? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response) _____
(*Required)

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

Q6: Does the member have a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in FEV1, reduction in oral corticosteroid dose)? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response) _____
(*Required)

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

Q7: Is the reqeusted medication prescribed by or in consultation with a pulmonologist or allergist/immunologist? (Check only one that apply)

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

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

Q8: Does the member continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) unless there is a contraindication or intolerance to these medications? (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 medical justification for continuation of therapy)
_____(*Required)

Q9: Is the member currently being treated with additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications? (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 medical justification for continuation of therapy)
_____(*Required)

Q10: Is the reqeusted medication prescribed by or in consultation with an otolaryngologist, allergist/immunologist, or pulmonologist? (Check only one that apply)

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

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

Q11: Does the member have a documentation of a positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS, 0-8 scale], improvement in nasal congestion/obstruction score [NC, 0-3 scale])? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response and the corresponding score(s))
_____(*Required)

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

Q12: Is the requested medication being used in combination with another chronic rhinosinusitis with nasal polyposis agent? (Check only one that apply)

[ ] Yes

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

Q13: Does the member have a documentation of a positive clinical response to therapy as evidenced by improvement of at least one of the following from baseline: symptoms (eg, dysphagia, food impaction, chest pain, heartburn), histologic measures (eg, esophageal intraepithelial eosinophil count), or endoscopic measures (eg, edema, furrows, exudates, rings, strictures)? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response) _____
(*Required)

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

Q14: Does the member have a positive clinical response to therapy? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response) _____
(*Required)

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

Q15: What is the member's diagnosis? (Check only one that apply)

[ ] Moderate to severe atopic dermatitis (AD)

[ ] Moderate to severe eosinophilic asthma (EA)

[ ] Moderate to severe corticosteroid dependent asthma (CDA)

[ ] Chronic rhinosinusitis with nasal polyposis (CRSwNP)

[ ] Eosinophilic esophagitis (EoE)

[ ] Prurigo Nodularis (PN)

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

Q16: Member meets which of the following criteria: (Check only one that apply)

[ ] Involvement of at least 10% body surface area (BSA)

[ ] SCORing Atopic Dermatitis (SCORAD) index value of at least 25

[ ] No (please provide medical justification for the request) _____ (*Required)

Q17: Has the member had an inadequate response, contraindication(s) (eg, safety concerns, not indicated for patient's age/weight), or have intolerance to an at least 14 day trial of medium or higher potency topical 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 (please provide medical justification for the request) _____ (*Required)

Q18: Has the member had an inadequate response, contraindication(s) (eg, safety concerns, not indicated for patient's age/weight), or have intolerance to an at least 30 day trial of pimecrolimus cream? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q19: Has the member had an inadequate response, contraindication(s) (eg, safety concerns, not indicated for patient's age/weight), or have intolerance to an at least 30 day trial of tacrolimus ointment? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q20: Has the member had an inadequate response, contraindication(s) (eg, safety concerns, not indicated for patient's age/weight), or have intolerance to an at least 30 day trial of Eucrisa (crisaborole) ointment? (Check only one that apply)

[ ] Yes (please specify 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)

Q21: Is the member at least 6 years old? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request) _____(*Required)

Q22: Is the reqeusted medication prescribed by or in consultation with a dermatologist, allergist/immunologist? (Check only one that apply)

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

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

Q23: Is the member at least 6 years old? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request) _____(*Required)

Q24: Does the member have eosinophilic phenotype of asthma as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter? (Check only one that apply)

[ ] Yes (please provide baseline (pre-treatment) peripheral blood eosinophil levl nd the date of test) _____(*Required)

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

Q25: Member's meets one of the following statements: (Check only one that apply)

[ ] Member has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months

[ ] Member has had prior asthma-related hospitalization within the past 12 months

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

Q26: Is the reqeusted medication prescribed by or in consultation with a pulmonologist or allergist/immunologist? (Check only one that apply)

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

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

Q27: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Fasenra (benralizumab), Nucala (mepolizumab), or Cinqair (reslizumab)? (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

Q28: Is the request for continuation of prior therapy? (Check only one that apply)

[ ] Yes

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

Q29: Is the member at least 6 years old? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request) _____(*Required)

Q30: Is the reqeusted medication prescribed by or in consultation with a pulmonologist or allergist/immunologist? (Check only one that apply)

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

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

Q31: Is the member currently dependent on oral corticosteroids for the treatment of asthma? (Check only one that apply)

[ ] Yes _____(*Required)

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

Q32: Does the member continues to be treated with a High-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day] unless there is a contraindication or intolerance to these medications? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q33: Is the member currently being treated with additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications? (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 _____(*Required)

Q34: Is the member currently being treated one max-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone/vilanterol)] unless there is a contraindication or intolerance to these medications? (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)

Q35: Has the member had an inadequate response or experienced contraindication(s) to 2 months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone)? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) and the start and end date(s) of therapy (month/year)) _____(*Required)

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

Q36: Will the request be used in combination with another agent for chronic rhinosinusitis with nasal polyposis? (Check only one that apply)

[ ] Yes

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

Q37: Is the reqeusted medication prescribed by or in consultation with an otolaryngologist, allergist/immunologist, or pulmonologist? (Check only one that apply)

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

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

Q38: Is the member at least 12 years old? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request) _____(*Required)

Q39: Does the member has symptoms of esophageal dysfunction (eg, dysphagia, food impaction, gastroesophageal reflux disease [GERD]/heartburn symptoms, chest pain, abdominal pain)? (Check only one that apply)

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

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

Q40: Is there any other conditions that causes of esophageal eosinophilia have been excluded? (Check only one that apply)

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

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

Q41: Does the member has at least 15 intraepithelial eosinophils per high power field (HPF)? (Check only one that apply)

[ ] Yes (please specify the number of intraepithelial eosinophils per HPF) _____(*Required)

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

Q42: Is the member atleast 40 kg? (Check only one that apply)

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

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

Q43: Has the member had an inadequate response, contraindication(s) or have intolerance to at least an 8-week trial of one of the following: proton pump inhibitors (eg, pantoprazole, omeprazole) or topical (esophageal) corticosteroids (eg, budesonide, fluticasone)? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) and the start and end date(s) of therapy (month/year)) _____(*Required)

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

Q44: Is the reqeusted medication prescribed by or in consultation with a gastroenterologist or allergist/immunologist? (Check only one that apply)

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

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

Q45: Has the member had an inadequate response, contraindication(s) or have intolerance to one medium or higher potency topical corticosteroid? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) and the start and end date(s) of therapy (month/year)) _____(*Required)

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

Q46: Is the reqeusted medication prescribed by or in consultation with one of the following: dermatologist, allergist/immunologist? (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:	