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):	[ ] Enbrel SureClick 50 mg/mL (1 mL) subcutaneous pen injector
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)

[ ] Moderately to severely active rheumatoid Arthritis

[ ] Moderately to severely active polyarticular juvenile idiopathic arthritis

[ ] Psoriatic Arthritis

[ ] Moderately to severely active plaque psoriasis

[ ] Ankylosing Spondylitis

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

Q4: Does the member have a positive clinical response to the 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 specify the type of positive clinical response) _____
(*Required)

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

Q5: Does the member have a positive clinical response to the 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 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 the therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (e.g., pruritus, inflammation) from baseline? (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: Does the member have a positive clinical response to the therapy as evidenced by improvement from baseline for at least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values pertaining to erythrocyte sedimentation rate, C-reactive protein level (please specify the test and lab values, and the date for lab test) 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 specify the type of positive clinical response) _____
(*Required)

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

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

[ ] Moderately to severely active rheumatoid Arthritis

[ ] Moderately to severely active polyarticular juvenile idiopathic arthritis

[ ] Psoriatic Arthritis

[ ] Moderately to severely active plaque psoriasis

[ ] Ankylosing Spondylitis

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

Q9: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least a 3 months trial of one of the following conventional therapies: methotrexate, leflunomide or sulfasalazine? (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 clinical rationale for the request) _____ (*Required)

Q10: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least a 6 weeks trial of one of the following conventional therapies: leflunomide or methotrexate? (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 clinical rationale for the request) _____ (*Required)

Q11: Member's diagnosis is supported by one of the following: (Check only one that apply)

[ ] Actively inflamed joints

[ ] Dactylitis

[ ] Enthesitis

[ ] Axial disease

[ ] Active skin and/or nail involvement

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

Q12: Member's diagnosis is supported by one 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 provide clinical rationale for the request) _____ (*Required)

Q13: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least a 4 weeks trial of one of the following topical therapies: corticosteroids (e.g., betamethasone, clobetasol), vitamin D analogs (e.g., calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), anthralin, or coal tar? (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 clinical rationale for the request) _____ (*Required)

Q14: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least 1 month trial of one nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen) at maximally tolerated doses? (Check only one that apply)

[ ] Yes (please specify drug name(s) along with dose; 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)

Q15: Is the requested drug prescribed by or in consultation with a rheumatologist? (Check only one that apply)

[ ] Yes

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

Q16: Is the requested drug prescribed by or in consultation with a rheumatologist or dermatologist? (Check only one that apply)

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

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

Q17: Is the requested drug prescribed by or in consultation with a dermatologist? (Check only one that apply)

[ ] Yes

[ ] 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:	