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):	[ ] Enjaymo 50 mg/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: 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)

[ ] Cold agglutinin disease (CAD)

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

Q4: Does the member have documentation supporting a positive clinical response to therapy as evidenced by not requiring any blood transfusions after the first 5 weeks of therapy with Enjaymo? (Check only one that apply)

[ ] Yes (please provide documentation(s) supporting the positive response of the therapy)
_____(*Required)

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

Q5: Does the member have documentation supporting a positive clinical response to therapy as evidenced by hemoglobin level greater than or equal to 12 gram per deciliter (g/dL) or increased greater than or equal to 2 g/dL from baseline? (Check only one that apply)

[ ] Yes (please provide documentation(s) supporting the positive response of the therapy)
_____(*Required)

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

Q6: Is the requested medication prescribed by or in consultation with an hematologist? (Check only one that apply)

[ ] Yes

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

Q7: Member meets one of the following weight criteria: (Check only one that apply)

[ ] Body weight at least 39 Kg but less than 75 Kg

[ ] Body weight 75 Kg or more

[ ] Other (please specify the weight) _____(*Required)

Q8: Does the prescribed dose exceeds 6,500 mg on day 0, 7, and every 14 days thereafter? (Check only one that apply)

[ ] Yes (please provide clinical rationale of the prescribed dose)
_____(*Required)

[ ] No

Q9: Does the prescribed dose exceeds 7,500 mg on day 0, 7, and every 14 days thereafter? (Check only one that apply)

[ ] Yes (please provide clinical rationale of the prescribed dose)
_____(*Required)

[ ] No

Q10: What is the member's diagnosis? (Check only one that apply)

[ ] Cold agglutinin disease (CAD)

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

Q11: Does the member's diagnosis is confirmed by presence of chronic hemolysis (e.g., bilirubin level above the normal reference range, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count)? (Check only one that apply)

[ ] Yes (please provide test date and result) _____(*Required)

[ ] No

Q12: Does the member's diagnosis is confirmed by positive polyspecific direct antiglobulin test (DAT)? (Check only one that apply)

[ ] Yes (please provide test date and result) _____(*Required)

[ ] No

Q13: Does the member's diagnosis is confirmed by monospecific direct antiglobulin test (DAT) strongly positive for C3d? (Check only one that apply)

[ ] Yes (please provide test date and result) _____(*Required)

[ ] No

Q14: Does the member diagnosis is confirmed by cold agglutinin titer greater than or equal to 64 measured at 4 degree celsius? (Check only one that apply)

[ ] Yes (please provide test date and result) _____(*Required)

[ ] No

Q15: Does the member diagnosis is confirmed by direct antiglobulin test (DAT) result for Immunoglobulin G (IgG) of 1+ or less ? (Check only one that apply)

[ ] Yes (please provide test date and result) _____(*Required)

[ ] No

Q16: Does the member have a cold agglutinin syndrome secondary to other factors (e.g., overt hematologic malignancy, primary immunodeficiency, infection, rheumatologic disease, systemic lupus erythematosus or other autoimmune disorders)? (Check only one that apply)

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

[ ] No (please provide supporting document) _____(*Required)

Q17: Does the member have a baseline hemoglobin level of 10.0 gram per deciliter (g/dL) or less? (Check only one that apply)

[ ] Yes (please specify the test, date of test and test result (s)) _____ (*Required)

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

Q18: Is the requested medication prescribed by or in consultation with an hematologist? (Check only one that apply)

[ ] Yes

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

Q19: Member meets one of the following weight criteria: (Check only one that apply)

[ ] Body weight at least 39Kg but less than 75Kg

[ ] Body weight 75Kg or more

[ ] Other (please specify the weight) _____(*Required)

Q20: Does the prescribed dose exceeds 6,500 mg on day 0, 7, and every 14 days thereafter? (Check only one that apply)

[ ] Yes (please provide clinical rationale of the prescribed dose)
_____(*Required)

[ ] No

Q21: Does the prescribed dose exceeds 7,500 mg on day 0, 7, and every 14 days thereafter? (Check only one that apply)

[ ] Yes (please provide clinical rationale of the prescribed dose)
_____(*Required)

[ ] No

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:	