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):	[ ] Entyvio 300 mg 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)

[ ] Moderately to severely active Ulcerative Colitis (UC)

[ ] Moderately to severely active Crohn's Disease (CD)

[ ] Other (please specify the member's diagnosis and provide 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: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline or reversal of high fecal output state? (Check only one that apply)

[ ] Yes (please explain and attach supporting documentation) _____
(*Required)

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

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Moderately to severely active Ulcerative Colitis (UC)

[ ] Moderately to severely active Crohn's Disease (CD)

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

Q6: Does the member have greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (e.g., hemoglobin, ESR, CRP), or is dependent on, or refractory to, corticosteroids? (Check only one that apply)

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

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

Q7: Is the request for continuation of prior therapy? (Check only one that apply)

[ ] Yes

[ ] No

Q8: Does the member have an inadequate response, intolerance or contraindication(s) to at least two of the following: Humira (adalimumab), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/XR (tofacitinib/ER)? (Check only one that apply)

[ ] Yes (please specify drug names and length of therapy for each, or, please explain if member is unable to try these drugs)
_____(*Required)

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

Q9: Does the member have frequent diarrhea and abdominal pain, at least 10% weight loss, complications (e.g., obstruction, fever, abdominal mass), abnormal lab values (e.g., CRP), or CD Activity Index (CDAI) greater than 220? (Check only one that apply)

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

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

Q10: Is the request for continuation of prior therapy? (Check only one that apply)

[ ] Yes

[ ] No

Q11: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Humira? (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

Q12: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Stelara? (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)

Q13: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Skyrizi (risankizumab-rzaa)? (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)

Q14: Is the requested medication prescribed by or in consultation with a gastroenterologist? (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:	