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):	[ ] epoprostenol 0.5 mg intravenous solution [ ] epoprostenol 1.5 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 request for a drug infused using an implantable pump? (Check only one that apply)

[ ] Yes

[ ] No

Q3: Will the requested drug be infused in the home with an external infusion pump? Note: A Hospital or Skilled Nursing Facility is not considered 'home' (Check only one that apply)

[ ] Yes

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

Q4: Request meets which of the following scenarios: Note: Professional services and supplies related to the administration of the drug are not payable (Check only one that apply)

[ ] Infusion drugs administered at home without an infusion pump (i.e., IV push, IV drip)

[ ] Infusion drugs administered by an external infusion pump in the home but not covered under the DME MAC LCD for Part B coverage

[ ] Infusion drugs administered by an external infusion pump outside the home (i.e., hospital, SNF)

[ ] None of the above (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: 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

Q6: What is the member's diagnosis? (Check only one that apply)

[ ] Pulmonary arterial hypertension (PAH)

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

Q7: Does the member have documentation supporting positive clinical response to therapy? (Check only one that apply)

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

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

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

[ ] Pulmonary arterial hypertension (PAH)

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

Q9: Does the member have pulmonary arterial hypertension (PAH) that is symptomatic? (Check only one that apply)

[ ] Yes

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

Q10: Member meets which one of the following: (Check only one that apply)

[ ] Member's diagnosis of PAH was confirmed by right heart catheterization

[ ] Member is currently on any therapy for the treatment of PAH (please specify the name of therapy) _____(*Required)

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

Q11: Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? (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:	