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):	[ ] Fasenra 30 mg/mL subcutaneous syringe
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)

[ ] Severe asthma

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

Q4: Does the member have documentation of 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 provide documentation of positive clinical response) ____(*Required)

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

Q5: Does the member continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without 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)

Q6: Is the request 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 medical justification for continuation of therapy) ____(*Required)

Q7: What is the member's diagnosis? (Check only one that apply)

[ ] Severe asthma

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

Q8: Does the member have asthma which is eosinophilic phenotype and defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter? (Check only one that apply)

[ ] Yes (Please provide the lab values) ____(*Required)

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

Q9: Has the member had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months? (Check only one that apply)

[ ] Yes (Please specify drug names) ____(*Required)

[ ] No ____(*Required)

Q10: Has the member had prior asthma-related hospitalization within the past 12 months? (Check only one that apply)

[ ] Yes (Please provide dates of hospitalization) ____(*Required)

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

Q11: Has the member had an intolerance or experienced contraindication(s) to high-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)? (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)

Q12: Has the member had an intolerance or experienced contraindication(s) to additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)? (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)

Q13: Has the member had an intolerance or experienced contraindication(s) to one maximally-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone/vilanterol)]? (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)

Q14: Is the member at least 12 years of age or older? (Check only one that apply)

[ ] Yes

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

Q15: Is the request 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 medical justification for continuation of therapy) ____(*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:	