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):	[ ] GamaSTAN S/D 15 %-18 % Range intramuscular syringe [ ] GamaSTAN S/D 15 %-18 % range intramuscular 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

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please provide clinical rationale for requesting additional therapy)
_____(*Required)

[ ] No

[ ] Yes (please provide clinical rationale for requesting additional therapy)
_____(*Required)

[ ] No

Q3: What is the intended use for Gamastan? (Check only one that apply)

[ ] For hepatitis A prophylaxis

[ ] For measles prophylaxis

[ ] For varicella (chickenpox) infection prophylaxis

[ ] For rubella prophylaxis

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

[ ] For hepatitis A prophylaxis

[ ] For measles prophylaxis

[ ] For varicella (chickenpox) infection prophylaxis

[ ] For rubella prophylaxis

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

Q4: Does the member have any contraindication to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication)? (Check only one that apply)

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

[ ] No

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

[ ] No

Q5: Is the requested medication being administered intramuscularly? (Check only one that apply)

[ ] Yes

[ ] No (please specify route of administration) _____(*Required)

[ ] Yes

[ ] No (please specify route of administration) _____(*Required)

Q6: Will the requested medication be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis? (Check only one that apply)

[ ] Yes (please specify dose and member's weight) _____ (*Required)

[ ] No (please specify dose, member's weight, and justification to support dose higher than minimum effective dose/frequency) _____(*Required)

[ ] Yes (please specify dose and member's weight) _____ (*Required)

[ ] No (please specify dose, member's weight, and justification to support dose higher than minimum effective dose/frequency) _____(*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:	