

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):	<input type="checkbox"/> Hizentra 1 gram/5 mL (20 %) subcutaneous solution <input type="checkbox"/> Hizentra 1 gram/5 mL (20 %) subcutaneous syringe <input type="checkbox"/> Hizentra 10 gram/50 mL (20 %) subcutaneous solution <input type="checkbox"/> Hizentra 10 gram/50 mL (20 %) subcutaneous syringe <input type="checkbox"/> Hizentra 2 gram/10 mL (20 %) subcutaneous solution <input type="checkbox"/> Hizentra 2 gram/10 mL (20 %) subcutaneous syringe <input type="checkbox"/> Hizentra 4 gram/20 mL (20 %) subcutaneous solution <input type="checkbox"/> Hizentra 4 gram/20 mL (20 %) 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: Does the member have a diagnosis of primary immune deficiency disease? (Check only one that apply)

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Yes

No

Q3: Is the requested drug administered in the home? (Check only one that apply)

Yes

No

Q4: Does the member have provider determination that administration in the home is medically appropriate? (Check only one that apply)

Yes

No

Q5: Request is for the treatment of which of following autoimmune mucocutaneous blistering diseases? (Check only one that apply)

Biopsy-proven pemphigus vulgaris

None of the above (please specify the member's diagnosis and provide clinical rationale for the request)
_____ (*Required)

Pemphigus foliaceus

Bullous pemphigoid

Mucous membrane pemphigoid (a.k.a., cicatricial pemphigoid)

Epidermolysis bullosa acquisita

Q6: 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

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

Chronic inflammatory demyelinating polyneuropathy (CIDP)

Common variable immunodeficiency (CVID),

Congenital agammaglobulinemia (X-linked or autosomal recessive)

Severe combined immunodeficiencies (SCID)

Wiskott-Aldrich syndrome

Other primary immunodeficiency with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis.

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

Q8: Does the member lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine)? (Check only one that apply)

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Yes

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

Q9: Does the member have experienced an objective improvement on immune globulin therapy? (Check only one that apply)

Yes

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

Q10: Member meets which one of the following minimum effective dose for maintenance therapy? (Check only one that apply)

By decreasing the frequency of dose

By increasing the frequency of dose

By implementing both strategies

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

Q11: What is the member's diagnosis? (Check only one that apply)

Chronic inflammatory demyelinating polyneuropathy (CIDP)

Common variable immunodeficiency (CVID),

Congenital agammaglobulinemia (X-linked or autosomal recessive

Severe combined immunodeficiencies (SCID)

Wiskott-Aldrich syndrome

Other primary immunodeficiency with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis

Other (please specify the member's diagnosis and provide clinical rationale for the request)

(*Required)

Q12: Does the member lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine)? (Check only one that apply)

Yes

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

Q13: Will the request be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis? (Check only one that apply)

Yes

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

Q14: Is the requested medication being used subcutaneously? (Check only one that apply)

Yes

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

Q15: Is the requested medication prescribed by or in consultation with a physician who has specialized expertise in managing patients on SCIG therapy (e.g., immunologist, hematologist, neurologist)? (Check only one that apply)

Yes (please specify prescriber specialty)

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

Q16: Does the member have contraindications 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 provide clinical rationale for the request) _____
(*Required)

No _____ (*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: