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):	[ ] Intron A 10 million unit (1 mL) solution for injection [ ] Intron A 10 million unit/0.2 mL injection syringe [ ] Intron A 10 million unit/0.2 mL subcutaneous pen kit [ ] Intron A 10 million unit/mL injection kit [ ] Intron A 10 million unit/mL injection solution [ ] Intron A 18 million unit (1 mL) solution for injection [ ] Intron A 25 million unit solution for injection [ ] Intron A 3 million unit solution for injection [ ] Intron A 3 million unit/0.2 mL injection syringe [ ] Intron A 3 million unit/0.2 mL-6 doses subcutaneous pen kit [ ] Intron A 3 million unit/0.5 mL injection kit [ ] Intron A 3 million unit/0.5 mL injection solution [ ] Intron A 5 million unit solution for injection [ ] Intron A 5 million unit/0.2 mL injection syringe [ ] Intron A 5 million unit/0.2 mL subcutaneous pen kit [ ] Intron A 5 million unit/0.5 mL injection kit [ ] Intron A 5 million unit/0.5 mL injection solution [ ] Intron A 50 million unit (1 mL) solution for injection [ ] Intron A 6 million unit/mL injection 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

Prior Authorization Form

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)

[ ] Chronic hepatitis B infection

[ ] Chronic hepatitis C

[ ] Metastatic renal cell carcinoma (RCC)

[ ] Condylomata acuminata (genital or perianal)

[ ] Hairy cell leukemia

[ ] AIDS-related Kaposi's sarcoma

[ ] Malignant melanoma

[ ] Stage III or IV follicular Non-Hodgkin's Lymphoma

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

Q4: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic hepatitis B infection

[ ] Chronic hepatitis C

[ ] Metastatic renal cell carcinoma (RCC)

[ ] Condylomata acuminata (genital or perianal)

[ ] Hairy cell leukemia

[ ] AIDS-related Kaposi's sarcoma

[ ] Malignant melanoma

[ ] Stage III or IV follicular Non-Hodgkin's Lymphoma

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

Q5: Has the member previously been treated with interferon? (Check only one that apply)

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

[ ] No

Q6: Is the requested medication used in combination with ribavirin? (Check only one that apply)

[ ] Yes

[ ] No

Q7: Does the member have any contraindication(s) or intolerance to ribavirin? (Check only one that apply)

[ ] Yes (please specify 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)

Q8: Is the requested medication used in combination with Avastin (bevacizumab)? (Check only one that apply)

[ ] Yes

[ ] No

Q9: Is the requested drug prescribed by or in consultation with an oncologist? (Check only one that apply)

[ ] Yes

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

Q10: Does the member have decompensated liver disease? (Check only one that apply)

[ ] Yes (please provide medical justification for continuation of therapy) _____(*Required)

[ ] No

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:	