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):	[ ] Kalydeco 150 mg tablet [ ] Kalydeco 25 mg oral granules in packet [ ] Kalydeco 50 mg oral granules in packet [ ] Kalydeco 75 mg oral granules in packet
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 diagnosis? (Check only one that apply)

[ ] Cystic Fibrosis (CF)

[ ] 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 the therapy (i.e. improvement in lung function [percent predicted forced expiratory volume in one second (PPFEV1)], decreased number of pulmonary exacerbations) while on therapy? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response)

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

Q5: What is the member diagnosis? (Check only one that apply)

[ ] Cystic Fibrosis (CF)

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

Q6: Does the member have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)? (Check only one that apply)

[ ] Yes (please provide mutation type, date of test and the test type)
_____(*Required)

[ ] No

Q7: Is the member at least 4 months of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please specify the member's age) _____(*Required)

Q8: Is the requested medication prescribed by or in consultation with specialist affiliated with a CF care center or pulmonologist? (Check only one that apply)

[ ] Yes

[ ] 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:	