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):	[ ] Kerendia 10 mg tablet [ ] Kerendia 20 mg tablet
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
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)

[ ] Chronic kidney disease (CKD) associated with type 2 diabetes (T2D)

[ ] 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? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

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

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

[ ] Chronic kidney disease (CKD) associated with type 2 diabetes (T2D)

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

Q6: Does the member have urinary albumin-to-creatinine ratio (UACR) of 30 to 300 mg/g? (Check only one that apply)

[ ] Yes (Please specify the value) _____(*Required)

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

Q7: Does the member have estimated glomerular filtration rate (eGFR) 25 to 60 mL/min/1.73 m2? (Check only one that apply)

[ ] Yes (Please specify the value) _____(*Required)

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

Q8: Does the member have diabetic retinopathy? (Check only one that apply)

[ ] Yes

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

Q9: Does the member have UACR of greater than or equal to 300 mg/g? (Check only one that apply)

[ ] Yes (Please specify the value) _____(*Required)

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

Q10: Does the member have eGFR of 25 to 75 mL/min/1.73 m2? (Check only one that apply)

[ ] Yes (Please specify the value) _____(*Required)

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

Q11: Has the member tried generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril) for at least 30 days supply? (Check only one that apply)

[ ] Yes (Please specify the drug (s) name, and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q12: Has the member tried generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan) for at least 30 days supply? (Check only one that apply)

[ ] Yes (Please specify the drug (s) name, and the start and end date(s) of therapy (month/year))
_____(*Required)

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

Q13: Member continues to be on a maximally tolerated dose of generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)? (Check only one that apply)

[ ] Yes (Please specify the drug (s) name, and corresponding strength)
_____(*Required)

[ ] No

Q14: Member continues to be on a maximally tolerated dose of generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)? (Check only one that apply)

[ ] Yes (Please specify the drug (s) name, and corresponding strength)
_____(*Required)

[ ] No

Q15: Has the member had any contraindication or intolerance to ACE inhibitors (e.g., benazepril, lisinopril)? (Check only one that apply)

[ ] Yes (please specify drug name, 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)

Q16: Has the member had any contraindication or intolerance to ARBs (e.g., losartan, valsartan)? (Check only one that apply)

[ ] Yes (please specify drug name, 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)

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:	