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):	[ ] Kesimpta Pen 20 mg/0.4 mL subcutaneous pen injector
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)

[ ] Relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions)

[ ] 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 (e.g., stability in radiologic disease activity, clinical relapse, or disease progression)? (Check only one that apply)

[ ] Yes (Please provide documentation supporting positive clinical response)
_____(*Required)

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

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

[ ] Relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions)

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

Q6: Has the member had an inadequate response, intolerance or experienced contraindication(s) to one of the following for at least 4 weeks ? (Check only one that apply)

[ ] Aubagio (teriflunomide) (Please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] Mavenclad (cladribine) (Please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] Plegridy (peginterferon beta-1a) (Please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] Any one of the interferon beta-1a injections (eg, Avonex) (Please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] Any one of the interferon beta-1b injections (eg, Betaseron, Extavia) (Please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] Any one of the oral fumarates (eg, brand Tecfidera, generic dimethyl fumarate) (Please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] Any one of the glatiramer acetates (eg, Copaxone, Glatopa, generic glatiramer acetate) (Please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (eg, Gilenya [fingolimod], Mayzent [siponimod], Zeposia [ozanimod]) (Please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] None of the above

Q7: Is the request for continuation of prior therapy? (Check only one that apply)

[ ] Yes

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

Q8: Is the requested medication used in combination with another disease-modifying therapy for MS? (Check only one that apply)

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

[ ] No

Q9: Is the requested medication used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ocrelizumab [Ocrevus])? (Check only one that apply)

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

[ ] No

Q10: Is the requested medication prescribed by or in consultation with an neurologist? (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:	