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):	[ ] Lemtrada 12 mg/1.2 mL intravenous 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

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., 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: Has the member been previously treated with alemtuzumab? (Check only one that apply)

[ ] Yes

[ ] No

Q5: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least a 4 weeks trial of two of the following disease-modifying therapies for Multiple Sclerosis: Aubagio (teriflunomide), Mavenclad (cladribine), Plegridy (peginterferon beta-1a), Tysabri (natalizumab), any one of the interferon beta-1a injections (e.g., Avonex), any one of the interferon beta-1b injections (e.g., Betaseron, Extavia), any one of the oral fumarates (e.g., brand Tecfidera, generic dimethyl fumarate), any one of the glatiramer acetate injections (e.g., Copaxone, Glatopa, generic glatiramer acetate), any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (e.g., Gilenya [fingolimod], Mayzent [siponimod], Zeposia [ozanimod]), any one of the B-cell targeted therapies (e.g., Ocrevus [ocrelizumab], Kesimpta [ofatumumab])? (Check only one that apply)

[ ] Yes (please specify drug names, 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)

Q6: Does the member have at least 12 months elapsed or will have elapsed since the most recent treatment course with alemtuzumab? (Check only one that apply)

[ ] Yes

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

Q7: Will the request be 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

Q8: Is the requested drug prescribed by or in consultation with a 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:	