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):	[ ] Lupron Depot 11.25 mg (3 month) intramuscular syringe kit [ ] Lupron Depot 22.5 mg (3 month) intramuscular suspension [ ] Lupron Depot 22.5 mg (3 month) intramuscular syringe kit
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – 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)

[ ] Prostate Cancer

[ ] Endometriosis

[ ] Uterine Leiomyomata (UL)

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

Q4: Requested medication will be used for one of the following: (Check only one that apply)

[ ] Anemia caused by Uterine Leiomyomata

[ ] Fibroids prior to surgery of Uterine Leiomyomata

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

[ ] Prostate Cancer

[ ] Endometriosis

[ ] Uterine Leiomyomata (UL)

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

Q6: Does the member have advanced or metastatic disease? (Check only one that apply)

[ ] Yes (please specify the member's diagnosis) _____(*Required)

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

Q7: Request is for one of the following strength? (Check only one that apply)

[ ] 7.5 mg

[ ] 22.5 mg

[ ] 30 mg

[ ] 45 mg

[ ] Other (please provide clinical strength) _____(*Required)

Q8: Has the member had surgical ablation to prevent recurrence? (Check only one that apply)

[ ] Yes

[ ] No

Q9: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least one NSAID (e.g., diclofenac, ibuprofen, meloxicam, naproxen)? (Check only one that apply)

[ ] Yes (please specify at least one 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)

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Q10: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least one oral contraceptive (e.g., norethindrone-ethinyl estradiol, estradiol and norethindrone)? (Check only one that apply)

[ ] Yes (please specify at least one 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)

Q11: Request is for one of the following strength? (Check only one that apply)

[ ] 3.75 mg

[ ] 11.25 mg

[ ] Other (please provide clinical strength) _____(*Required)

Q12: Request is for one of the following strength? (Check only one that apply)

[ ] 3.75 mg

[ ] 11.25 mg

[ ] Other (please provide clinical strength) _____(*Required)

Q13: Is the requested medication being used prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)? (Check only one that apply)

[ ] Yes

[ ] No

Q14: Is medication being used for the treatment of anemia? (Check only one that apply)

[ ] Yes

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

Q15: Is the anemia caused by uterine leiomyomata (fibroids)? (Check only one that apply)

[ ] Yes

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

Q16: Is medication being used prior to surgery? (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:	