

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):	[] Makena (PF) 275 mg/1.1 mL subcutaneous auto-injector
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 provide clinical rationale for the request) _____
(*Required)

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☐ No

Q3: What is the member's diagnosis? (Check only one that apply)

☐ Preterm birth prophylaxis

☐ Other (please specify the member's diagnosis and provide clinical rationale for the request)

_____*Required)

Q4: Has the member had a previous singleton (single offspring) spontaneous preterm birth? (Check only one that apply)

☐ Yes

☐ No (please provide clinical rationale for the request)

_____*Required)

Q5: Is the member having a singleton pregnancy? (Check only one that apply)

☐ Yes

☐ No (please provide clinical rationale for the request)

_____*Required)

Q6: Will therapy with Makena be started between 16 weeks, 0 days and 20 weeks, 6 days of gestation? (Check only one that apply)

☐ Yes

☐ No (please provide clinical rationale for the request)

_____*Required)

Q7: Will therapy with Makena be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first? (Check only one that apply)

☐ Yes

☐ No (please provide clinical rationale for the request)

_____*Required)

Q8: Is the requested medication prescribed by or in consultation with a gynecologist or obstetrician? (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: