

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):	<input type="checkbox"/> Natpara 100 mcg/dose subcutaneous cartridge <input type="checkbox"/> Natpara 25 mcg/dose subcutaneous cartridge <input type="checkbox"/> Natpara 50 mcg/dose subcutaneous cartridge <input type="checkbox"/> Natpara 75 mcg/dose subcutaneous cartridge
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)

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Hypocalcemia due to chronic hypoparathyroidism

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

Q4: Does the member have documentation supporting positive clinical response to therapy? (Check only one that apply)

Yes (please provide documentation(s) supporting the positive response of the therapy)
_____ (*Required)

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

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

Hypocalcemia due to chronic hypoparathyroidism

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

Q6: Does the prescribed medication used in the setting of acute post-surgical hypoparathyroidism? (Check only one that apply)

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

No

Q7: Does the member have a known calcium-sensing receptor mutation? (Check only one that apply)

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

No

Q8: Does the member have a documented parathyroid hormone concentration that is inappropriately low for the level of calcium, recorded on at least two occasions within the previous 12 months? (Check only one that apply)

Yes (please provide supporting documentation) _____
(*Required)

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

Q9: Does the member have normal thyroid-stimulating hormone concentrations if not on thyroid hormone replacement therapy (or if on therapy, the dose had to have been stable for greater than or equal to 3 months)? (Check only one that apply)

Yes (Please specify the details) _____ (*Required)

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

Q10: Does the member have normal magnesium and serum 25-hydroxyvitamin D concentrations? (Check only one that apply)

Yes (please provide member's magnesium, serum 25-hydroxyvitamin D concentrations)
_____ (*Required)

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

Q11: Will requested medication be used as an adjunct treatment? (Check only one that apply)

Yes

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

Q12: Is the requested medication prescribed by or in consultation with an endocrinologist? (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:	