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):	[ ] Neulasta Onpro 6 mg/0.6 mL with wearable subcutaneous 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 list start date of therapy (month/day/year)) _____

(*Required)

[ ] No

Q3: Is the reqeusted medication prescribed by or in consultation with a hematologist/oncologist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty) _____(*Required)

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

Q4: What is the member's diagnosis? (Check only one that apply)

[ ] Acute radiation syndrome (ARS)

[ ] Febrile neutropenia (FN)

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

Q5: Is the requested medication prescribed for febrile neutropenia (FN) prophylaxis? (Check only one that apply)

[ ] Yes

[ ] No _____(*Required)

Q6: Was the member or will the member be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS)? (Check only one that apply)

[ ] Yes (please specify the date(s) of radiation (month/year)) _____ (*Required)

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

Q7: Has the member received or is receiving myelosuppressive anticancer drugs associated with neutropenia? (Check only one that apply)

[ ] Yes (please specify the drugs name and the start and end date(s) of therapy (month/year)) _____(*Required)

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

Q8: Does the member have febrile neutropenia and is at high risk for infection-associated complications? (Check only one that apply)

[ ] Yes (please provide the supporting documentation) _____ (*Required)

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

Q9: Is the member receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer? (Check only one that apply)

[ ] Yes (please provide the supporting documentation) _____ (*Required)

[ ] No

Q10: Is the member receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown? (Check only one that apply)

[ ] Yes (please provide the supporting documentation) _____ (*Required)

[ ] No

Q11: Is the member receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN? (Check only one that apply)

[ ] Yes (please provide the supporting documentation) _____ (*Required)

[ ] No

Q12: Is the member receiving chemotherapy regimen(s) associated with 10-20% incidence of FN? (Check only one that apply)

[ ] Yes (please provide the supporting documentation) _____ (*Required)

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

Q13: Does the member have one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia? (Check only one that apply)

[ ] Yes (please provide the supporting documentation) _____ (*Required)

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

Q14: Is the member receiving myelosuppressive anticancer drugs associated with neutropenia? (Check only one that apply)

[ ] Yes (please specify the drugs name and the start and end date(s) of therapy (month/year)) _____(*Required)

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

Q15: Does the member have a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis)? (Check only one that apply)

[ ] Yes (please provide the supporting documentation) _____ (*Required)

[ ] 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:	