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):	[ ] Nucala 100 mg subcutaneous solution [ ] Nucala 100 mg/mL subcutaneous auto-injector [ ] Nucala 100 mg/mL subcutaneous syringe [ ] Nucala 40 mg/0.4 mL subcutaneous syringe
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)

[ ] Severe asthma

[ ] Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

[ ] Eosinophilic Granulomatosis with Polyangiitis (EGPA)

[ ] Hypereosinophilic Syndrome (HES)

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

Q4: Does the member have documentation of positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications)? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response)
_____(*Required)

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

Q5: Does the member continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) or intolerance experienced and the start and end date (s) of therapy (month/year)) _____(*Required)

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

Q6: Is the requested medication prescribed by or in consultation with a pulmonologist or allergist/immunologist? (Check only one that apply)

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

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

Q7: Does the member have documentation of positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS, 0-8 scale], improvement in nasal obstruction symptoms via visual analog scale [VAS, 0-10 scale])? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response)
_____(*Required)

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

Q8: Does the member have documentation of positive clinical response to therapy (e.g., increase in remission time)? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response)
_____(*Required)

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

Q9: Documentation of positive clinical response to therapy (e.g., reduction in flares, decreased blood eosinophil count, reduction in corticosteroid dose)? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response)
_____(*Required)

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

Q10: What is the member's diagnosis? (Check only one that apply)

[ ] Severe asthma

[ ] Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

[ ] Eosinophilic Granulomatosis with Polyangiitis (EGPA)

[ ] Hypereosinophilic Syndrome (HES)

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

Q11: Does the member have asthma which is eosinophilic phenotype and defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter within the past 12 months? (Check only one that apply)

[ ] Yes

[ ] No

Q12: Does the member have asthma in which peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months? (Check only one that apply)

[ ] Yes

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

Q13: Has the member had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months? (Check only one that apply)

[ ] Yes

[ ] No

Q14: Has the member had prior asthma-related hospitalization within the past 12 months? (Check only one that apply)

[ ] Yes

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

Q15: Has the member had an intolerance or experienced contraindication(s) to high-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) or intolerance experienced and the start and end date (s) of therapy (month/year)) _____(*Required)

[ ] No

Q16: Has the member had an intolerance or experienced contraindication(s) to additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) or intolerance experienced and the start and end date (s) of therapy (month/year)) _____(*Required)

[ ] No

Q17: Has the member had an intolerance or experienced contraindication(s) to one maximally-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone/vilanterol)]? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q18: Is the member at least 6 years of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age and provide clinical rationale for the request) _____(*Required)

Q19: Is the request prescribed by or in consultation with a pulmonologist or allergist/immunologist? (Check only one that apply)

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

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

Q20: Has the member had an inadequate response or experienced contraindication(s) to 2 months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone)? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

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

Q21: Is the requested medication used in combination with another agent for CRSwNP? (Check only one that apply)

[ ] Yes

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

Q22: Is the requested medication prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist? (Check only one that apply)

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

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

Q23: Is the disease relapsed or refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)? (Check only one that apply)

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

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

Q24: Does the member currently receiving corticosteroid therapy (e.g., prednisolone, prednisone)? (Check only one that apply)

[ ] Yes

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

Q25: Is the requested medication prescribed by or in consultation with a pulmonologist, rheumatologist or allergist/immunologist? (Check only one that apply)

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

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

Q26: Does the member diagnosed with HES for at least 6 months. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy)? (Check only one that apply)

[ ] Yes (please specify the cause) _____(*Required)

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

Q27: Is the member FIP1L1-PDGFRA-negative? (Check only one that apply)

[ ] Yes

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

Q28: Does the member have uncontrolled HES defined as History of 2 or more flares within the past 12 months? (Check only one that apply)

[ ] Yes

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

Q29: Does the member have uncontrolled HES defined as Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter? (Check only one that apply)

[ ] Yes

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

Q30: Has the member had an inadequate response, intolerance or experienced contraindication(s) to corticosteroid therapy (e.g., prednisone) or cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib)? (Check only one that apply)

[ ] Yes (please specify 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)

Q31: Is the requested medication prescribed by or in consultation with an allergist/immunologist or hematologist? (Check only one that apply)

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

Prior Authorization Form

Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	