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):	[ ] Opzelura 1.5 % topical cream
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)

[ ] Mild to moderate atopic dermatitis (AD)

[ ] Nonsegmental Vitiligo (NV)

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

Q4: Does the member have documentation of a positive clinical response to therapy as evidenced by reduction in body surface area (BSA) involvement from baseline? (Check only one that apply)

[ ] Yes (please provide supporting documents) ____(*Required)

[ ] No

Q5: Does the member have documentation of a positive clinical response to therapy as evidenced by reduction in pruritus severity from baseline? (Check only one that apply)

[ ] Yes (please provide supporting documents) ____(*Required)

[ ] No

Q6: Does the member have documentation of a positive clinical response to therapy as evidenced by improvement in quality of life from baseline? (Check only one that apply)

[ ] Yes (please provide supporting documents) ____(*Required)

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

Q7: Is the member receiving Opzelura in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? (Check only one that apply)

[ ] Yes (please specify the drug name(s) and provide clinical rationale for the request) ____(*Required)

[ ] No

Q8: Will Opzelura only be used for short-term and/or non-continuous chronic treatment? (Check only one that apply)

[ ] Yes

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

Q9: Does the member have documentation of a positive clinical response to therapy? (Check only one that apply)

[ ] Yes

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

Q10: Is the member receiving Opzelura in combination with therapeutic biologics, other JAK inhibitors, or potent immunosuppressants (eg, azathioprine or cyclosporine)? (Check only one that apply)

[ ] Yes (please specify the drug name(s) and provide clinical rationale for the request) ____(*Required)

[ ] No

Q11: What is the member's diagnosis? (Check only one that apply)

[ ] Mild to moderate atopic dermatitis (AD)

[ ] Nonsegmental Vitiligo (NV)

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

Q12: Is the member at least 12 years old? (Check only one that apply)

[ ] Yes

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

Q13: Is the affected area greater than or equal to 3% body surface area (BSA) involvement? (Check only one that apply)

[ ] Yes (please provide supporting documents) ____(*Required)

[ ] No

Q14: Does the atopic dermatitis involves sensitive body areas (e.g., face, hands, feet, scalp, groin)? (Check only one that apply)

[ ] Yes (please specify the area involvement) ____(*Required)

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

Q15: Has the member had an inadequate response to minimum 30-day supply (14-day supply for topical corticosteroids), contraindication(s) or have intolerance to at least two of the following: a) Medium or higher potency topical corticosteroid, b) Elidel (pimecrolimus) cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment? (Check only one that apply)

[ ] Yes (please specify 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)

Q16: Is the member receiving Opzelura in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? (Check only one that apply)

[ ] Yes (please specify the drug name(s) and provide clinical rationale for the request) ____(*Required)

[ ] No

Q17: Will Opzelura only be used for short-term and/or non-continuous chronic treatment? (Check only one that apply)

[ ] Yes

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

Q18: Is the reqeusted medication prescribed by or in consultation with a dermatologist, allergist/immunologist? (Check only one that apply)

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

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

Q19: Has the member had an inadequate response, contraindication(s) or have intolerance to at least one of the following: medium or higher potency topical corticosteroid or tacrolimus ointment? (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 medical justification for the request) ____
(*Required)

Q20: Is the member receiving Opzelura in combination with therapeutic biologics, other JAK inhibitors, or potent immunosuppressants (eg, azathioprine or cyclosporine)? (Check only one that apply)

[ ] Yes (please specify the drug name(s) and provide clinical rationale for the request) ____(*Required)

[ ] No

Q21: Is the member at least 12 years old? (Check only one that apply)

[ ] Yes

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

Q22: Is the reqeusted medication prescribed by or in consultation with a dermatologist? (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.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	