

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"/> Panzyga 10 % intravenous solution
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: Does the member have a diagnosis of primary immune deficiency disease? (Check only one that apply)

Yes

Prior Authorization Form



No

Q3: Is the requested drug administered in the home? (Check only one that apply)

Yes

No

Q4: Does the member have provider determination that administration in the home is medically appropriate? (Check only one that apply)

Yes

No

Q5: Request is for the treatment of which of following autoimmune mucocutaneous blistering diseases? (Check only one that apply)

Biopsy-proven pemphigus vulgaris

None of the above (please specify the member's diagnosis and provide clinical rationale for the request)

_____ (*Required)

Pemphigus foliaceus

Bullous pemphigoid

Mucous membrane pemphigoid (a.k.a., cicatricial pemphigoid)

Epidermolysis bullosa acquisita

Q6: Does the member have contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication). Privigen only: Hyperprolinemia. Octagam only: Allergy to corn? (Check only one that apply)

Yes (please specify drug name and corresponding experienced contraindication(s))

_____ (*Required)

No

Q7: 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

Q8: Is the requested medication prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist)? (Check only one that apply)

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

No (please provide medical justification for continuation of therapy)

_____ (*Required)

Q9: What is the member's diagnosis? (Check only one that apply)

Primary Immunodeficiency

Secondary Acquired Antibody Deficiency

Hematological Autoimmune Disorders

Prior Authorization Form



Neuromuscular Autoimmune Disorders

Other Disorders

None of the above (please specify the member's diagnosis and provide clinical rationale for the request)
_____ (*Required)

Q10: Is the request for one of the following? (Check only one that apply)

Autoimmune blistering disease

Kawasaki syndrome

Solid organ transplant

Non-Oncology renewal (please specify member's diagnosis)
_____ (*Required)

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

Q11: Is the request for one of the following? (Check only one that apply)

Intravenous immunoglobulin (IVIG)

Subcutaneous immunoglobulin (SCIG)

None of the above (please provide clinical rationale for the request)
_____ (*Required)

Q12: What is the member's diagnosis? (Check only one that apply)

Primary Immunodeficiency

Secondary Acquired Antibody Deficiency

Hematological Autoimmune Disorders

Neuromuscular Autoimmune Disorders

Other Disorders

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

Q13: Is the request for one of the following? (Check only one that apply)

Common variable immunodeficiency

Congenital agammaglobulinemia (X-linked or autosomal recessive)

Severe combined immunodeficiencies

Wiskott-Aldrich syndrome

Other Primary Immunodeficiency

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

Prior Authorization Form



Q14: Does the member has an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis? (Check only one that apply)

Yes

No (please provide clinical rationale for the request) _____

(*Required)

Q15: Does the member lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine)? (Check only one that apply)

Yes

No (please provide clinical rationale for the request) _____

(*Required)

Q16: Is the request for one of the following? (Check only one that apply)

B-cell chronic lymphocytic leukemia

HIV infection

Multiple myeloma in plateau phase

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

(*Required)

Q17: Does the member have Ig level less than 500 mg/dL? (Check only one that apply)

Yes

No

Q18: Does the member have history of recurrent bacterial infections? (Check only one that apply)

Yes

No (please provide clinical rationale for the request) _____

(*Required)

Q19: Does the member have Ig level less than 400 mg/dL? (Check only one that apply)

Yes

No

Q20: Does the member have active bleeding or a platelet count less than $10 \times 10^9/L$? (Check only one that apply)

Yes

No (please provide clinical rationale for the request) _____

(*Required)

Q21: Is the member less than or equal to 12 years old? (Check only one that apply)

Yes (please specify member's age) _____ (*Required)

No (please provide clinical rationale for the request) _____

(*Required)

Q22: Does the member have hypogammaglobulinemia? (Check only one that apply)

Prior Authorization Form



Yes

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

Q23: Is the request for one of the following? (Check only one that apply)

Immunologic acquired (pure) red cell aplasia (PRCA)

Fetal alloimmune thrombocytopenia

Hemolytic disease of the newborn

Idiopathic thrombocytopenic purpura

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

_____ (*Required)

Q24: Does the member have viral PRCA caused by parvovirus B19? (Check only one that apply)

Yes

No

Q25: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (i.e., cyclophosphamide, cyclosporine)? (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)

Q26: Does the member have established hyperbilirubinemia? (Check only one that apply)

Yes

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

Q27: Has the member had an inadequate response, intolerance or experienced contraindication(s) to a corticosteroid? (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

Q28: Does the member have platelet count less than 30,000 cells/mm³? (Check only one that apply)

Yes (please specify member's platelet count) _____ (*Required)

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

Q29: Is the request for one of the following? (Check only one that apply)

Chronic inflammatory demyelinating polyneuropathy

Guillain-Barre syndrome

Inflammatory myopathies (dermatomyositis or polymyositis)

Prior Authorization Form



- Lambert-Eaton myasthenic syndrome
- Multifocal motor neuropathy
- Myasthenia gravis with severe exacerbations
- Myasthenic crises
- Stiff person syndrome
- Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____ (*Required)

Q30: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (i.e., azathioprine, methotrexate, cyclosporine A, cyclophosphamide, or tacrolimus)? (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)

Q31: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (e.g., azathioprine)? (Check only one that apply)

- Yes (please specify 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)

Q32: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (i.e., azathioprine, cyclosporine, cyclophosphamide, or mycophenolate mofetil)? (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)

Q33: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least 2 standard therapies (i.e., benzodiazepines, muscle relaxants, or anti-convulsants)? (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)

Q34: Is the request for one of the following? (Check only one that apply)

- Autoimmune blistering disease
- Kawasaki syndrome
- Solid organ transplant
- Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____ (*Required)

Prior Authorization Form



Q35: Has the member had an inadequate response, intolerance or experienced contraindication(s) to an immunosuppressant (i.e., azathioprine, cyclosporine, cyclophosphamide, or mycophenolate mofetil)? (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)

Q36: Is the request for CMV prophylaxis? (Check only one that apply)

Yes

No

Q37: Is the member a kidney transplant recipient? (Check only one that apply)

Yes

No

Q38: Does the member have donor specific antibodies? (Check only one that apply)

Yes

No

Q39: Does the member have steroid-resistant rejection? (Check only one that apply)

Yes

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

Q40: Has the member had an inadequate response, intolerance or experienced contraindication(s) to standard therapies? (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)

Q41: Is the request for one of the following? (Check only one that apply)

Gamunex-C

None of the above (please provide clinical rationale for the request) _____ (*Required)

Gammaked

Q42: Is the request for one of the following? (Check only one that apply)

Common variable immunodeficiency

Congenital agammaglobulinemia (X-linked or autosomal recessive)

Severe combined immunodeficiencies

Wiskott-Aldrich syndrome

Prior Authorization Form



Other Primary immunodeficiency

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

Q43: Does the member has an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis? (Check only one that apply)

Yes

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

Q44: Does the member lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine)? (Check only one that apply)

Yes

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

Q45: Has the member had an inadequate response, intolerance or experienced contraindication(s) to a corticosteroid? (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)

Q46: Is the requested medication prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist)? (Check only one that apply)

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

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

Q47: Is the requested medication prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist)? (Check only one that apply)

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

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

Q48: Does the member has experienced an objective improvement on immune globulin therapy? (Check only one that apply)

Yes (please specify) _____ (*Required)

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

Q49: Is the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy? (Check only one that apply)

Yes (please specify) _____ (*Required)

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

Prior Authorization Form



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: