

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"/> Pemazyre 13.5 mg tablet <input type="checkbox"/> Pemazyre 4.5 mg tablet <input type="checkbox"/> Pemazyre 9 mg tablet
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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- Unresectable locally advanced cholangiocarcinoma
- Metastatic cholangiocarcinoma
- Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____ (*Required)

- Relapsed myeloid/lymphoid neoplasms
- Refractory myeloid/lymphoid neoplasms

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

- Unresectable locally advanced cholangiocarcinoma
- Metastatic cholangiocarcinoma
- Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____ (*Required)

- Relapsed myeloid/lymphoid neoplasms
- Refractory myeloid/lymphoid neoplasms

Q5: Does the member's disease have presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)? (Check only one that apply)

Yes (please provide test result(s) and date of test) _____
(*Required)

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

Q6: Has the member been previously treated? (Check only one that apply)

- Yes
- None (please provide clinical rationale for the request) _____
(*Required)

Q7: Does the member's disease have presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement? (Check only one that apply)

Yes (please provide test result(s) and date of test) _____
(*Required)

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

Q8: Is the requested medication prescribed by or in consultation with a hepatologist, gastroenterologist, or oncologist? (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.

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