

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):	[] Prolastin-C 1,000 mg (+-)/20 mL intravenous solution [] Prolastin-C 1,000 mg intravenous powder for 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: Is the member currently treated with this medication? (Check only one that apply)

Yes (please list start date of therapy (month/day/year)) _____
(*Required)

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No

Q3: What is the member's diagnosis? (Check only one that apply)

Emphysema due to congenital Alpha-1 antitrypsin (ATT) deficiency

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? (Check only one that apply)

Yes (please provide documentation(s) supporting the positive response of the therapy)
_____ (*Required)

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

Q5: Has the member continued conventional treatment for emphysema (e.g., bronchodilators)? (Check only one that apply)

Yes (please specify the drug name) _____ (*Required)

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

Q6: What is the member's diagnosis? (Check only one that apply)

Emphysema due to congenital Alpha-1 antitrypsin (ATT) deficiency

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

Q7: Has the member continued conventional treatment for emphysema (e.g., bronchodilators)? (Check only one that apply)

Yes (please specify the drug name) _____ (*Required)

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

Q8: Member meets any one of the followings? (Check only one that apply)

PiZZ, PiZ(null), or Pi(null)(null) protein phenotypes (homozygous) (Please specify the phenotypes)
_____ (*Required)

Other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 micro M/L [e.g., Pi(Malton, Malton), Pi(SZ)] ((Please specify the phenotypes) _____ (*Required)

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

Q9: Does the member have circulating pre-treatment serum AAT level less than 11 micro M/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry)? (Check only one that apply)

Yes (please specify the serum AAT level) _____ (*Required)

No

Q10: Does the member has a concomitant diagnosis of necrotizing panniculitis? (Check only one that apply)

Yes

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

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Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the HealthPlan, 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: