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):	[ ] Pulmozyme 1 mg/mL solution for inhalation
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 requested inhalation drug administered at home with the use of a nebulizer? (Check only one that apply)

[ ] Yes

[ ] No

Q3: Will the requested drug be used with a nebulizer during a stay in one of the following facilities: (Check only one that apply)

[ ] A hospital or skilled nursing facility (SNF)

[ ] A nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility

[ ] A Medicaid-only nursing facility that primarily furnishes skilled care

[ ] A non-participating nursing home (i.e., neither Medicare or Medicaid) that provides primarily skilled care

[ ] An institution which has a distinct part SNF and primarily furnishes skilled care

[ ] Long-term care facilities (LTC)

[ ] None of the above

Q4: Will the requested drug be delivered by a metered dose inhaler or other non-nebulized administration? (Check only one that apply)

[ ] Yes

[ ] No

Q5: 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

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

[ ] Cystic fibrosis (CF)

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

Q7: Is the member benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations)? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response) _____ (*Required)

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

Q8: What is the member's diagnosis? (Check only one that apply)

[ ] Cystic fibrosis (CF)

[ ] Other (please specify the member's diagnosis and 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:

Prior Authorization Form

Print Authorized Representative Name: