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):	[ ] Pyrukynd 20 mg (7)-5 mg (7) tablets in a dose pack [ ] Pyrukynd 20 mg tablet [ ] Pyrukynd 5 mg tablet [ ] Pyrukynd 50 mg (7)-20 mg (7) tablets in a dose pack [ ] Pyrukynd 50 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)

[ ] Hemolytic anemia

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

Q4: Is there documentation the member has had a positive clinical response to therapy [e.g., hemoglobin greater than or equal to 1.5g/dL from baseline, reduction in transfusions of greater than or equal to 33% in the number of red blood cell units transfused during the fixed dose period compared with the patient's historical transfusion burden, improvement in markers of hemolysis from baseline (e.g., bilirubin, lactated dehydrogenase [LDH], haptoglobin, reticulocyte count)]? (Check only one that apply)

[ ] Yes (please provide document(s) supporting positive response to therapy) ____(*Required)

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

Q5: Is the requested medication prescribed by or in consultation with an hematologist? (Check only one that apply)

[ ] Yes (please provide prescriber's specialty) ____(*Required)

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

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

[ ] Hemolytic anemia

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

Q7: Does the member have a diagnosis of hemolytic anemia confirmed by the presence of chronic hemolysis (e.g., increased indirect bilirubin, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count)? (Check only one that apply)

[ ] Yes (please specify test result and date of test) ____(*Required)

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

Q8: Does the member have a diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD) confirmed by molecular testing with the presence of at least two variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, with at least one being a missense variant? (Check only one that apply)

[ ] Yes (please specify test result and date of test) ____(*Required)

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

Q9: Does the member have homozygous for the c.1436G to A (p.R479H) variant? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) ____ (*Required)

[ ] No (please specify test result and date of test) ____(*Required)

Q10: Does the member have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) ____ (*Required)

[ ] No (please specify test result and date of test) ____(*Required)

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Q11: Does the member have hemoglobin is less than or equal to 10g/dL? (Check only one that apply)

[ ] Yes (please specify test result and date of test) ____(*Required)

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

Q12: Does the member have symptomatic anemia or transfusion dependent? (Check only one that apply)

[ ] Yes (please specify type of anemia) ____(*Required)

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

Q13: Does the member have other causes of hemolytic anemias (e. g., infections, toxins, drugs)? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) ____ (*Required)

[ ] No

Q14: Is the requested medication prescribed by or in consultation with an hematologist? (Check only one that apply)

[ ] Yes (please provide prescriber's 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:	