

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"/> Rebif Titration Pack 8.8 mcg/0.2 mL-22 mcg/0.5 mL subcutaneous syringe
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – 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
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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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Relapsing form of multiple Sclerosis (MS) (eg, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). (please specify the type of MS) \_\_\_\_\_  
(\*Required)

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

Q4: Will the requested drug be used as combination with another disease-modifying therapy for MS? (Check only one that apply)

Yes (please provide medical justification for continuation of therapy)  
\_\_\_\_\_ (\*Required)

No

Q5: Does the member have documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)? (Check only one that apply)

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

No (please provide medical justification for continuation of therapy)  
\_\_\_\_\_ (\*Required)

Q6: Is the requested medication prescribed by or in consultation with a neurologist? (Check only one that apply)

Yes

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

Q7: What is the member's diagnosis? (Check only one that apply)

Relapsing form of multiple Sclerosis (MS) (eg, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). (please specify the type of MS) \_\_\_\_\_  
(\*Required)

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

Q8: Has the member had an inadequate response, intolerance or experienced contraindication(s) to one of the following: Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Extavia (interferon beta-1b), Plegridy (peginterferon beta-1a)? (Check only one that apply)

Yes (please specify drug names, 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)

Q9: Is the request for continuation of prior therapy? (Check only one that apply)

Yes

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

Q10: Does the prescribed medication used combination with another disease-modifying therapy for MS? (Check only one that apply)

Yes (please provide clinical rationale for the request) \_\_\_\_\_  
(\*Required)

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No

Q11: Is the requested medication prescribed by or in consultation with a neurologist? (Check only one that apply)

Yes

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

<b>Attestation:</b> 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:	