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):	[ ] Renflexis 100 mg intravenous 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)

[ ] No

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

[ ] Moderately to severely active rheumatoid Arthritis (RA)

[ ] Moderately to severely active ulcerative colitis (UC)

[ ] Sarcoidosis

[ ] Chronic severe (i.e., extensive and/or disabling) plaque psoriasis

[ ] Ankylosing Spondylitis

[ ] Moderately to severely active Crohn's Disease (CD)

[ ] Active psoriatic arthritis (PsA)

[ ] Moderately to severely active fistulizing Crohn's Disease (FCD)

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

Q4: Does the member have a documentation of positive clinical response to therapy as evidenced by one of the following: (Check only one that apply)

[ ] Reduction in the BSA involvement from baseline (please provide the supporting documents)
_____(*Required)

[ ] Improvement in symptoms (e.g., pruritus, inflammation) from baseline (please provide the supporting documents)
_____(*Required)

[ ] Other (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: Does the member have a documentation of positive clinical response to therapy as evidenced by at least one of the following: (Check only one that apply)

[ ] Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline (e.g., mucosal healing (please provide the supporting documents)
_____(*Required)

[ ] Reversal of high fecal output state (please provide the supporting documents)
_____(*Required)

[ ] Other (please provide medical justification for continuation of therapy)
_____(*Required)

Q6: Does the member have a documentation of positive clinical response to therapy as evidenced by at least one of the following: (Check only one that apply)

[ ] Reduction in the total active (swollen and tender) joint count from baseline (please provide the supporting documents)
_____(*Required)

[ ] Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline (please provide the supporting documents)
_____(*Required)

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

Q7: Does the member have a documentation of positive clinical response to therapy as evidenced by at least one of the following: (Check only one that apply)

[ ] Reduction in the total active (swollen and tender) joint count from baseline (please provide the supporting documents) _____(*Required)

[ ] Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline (please provide the supporting documents) _____(*Required)

[ ] Reduction in the BSA involvement from baseline (please provide the supporting documents) _____(*Required)

[ ] Other (please provide medical justification for continuation of therapy) _____(*Required)

Q8: Does the member have a documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: (Check only one that apply)

[ ] Disease activity (e.g., pain, fatigue, inflammation, stiffness) (please provide the supporting documents) _____(*Required)

[ ] Lab values (erythrocyte sedimentation rate, C-reactive protein level) (please provide the supporting documents) _____(*Required)

[ ] Function, axial status (e.g., lumbar spine motion, chest expansion) (please provide the supporting documents) _____(*Required)

[ ] Total active (swollen and tender) joint count (please provide the supporting documents) _____(*Required)

[ ] Other (please provide medical justification for continuation of therapy) _____(*Required)

Q9: Does the member have a documentation of positive clinical response to therapy? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

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

Q10: What is the member's diagnosis? (Check only one that apply)

[ ] Moderately to severely active rheumatoid Arthritis

[ ] Moderately to severely active ulcerative colitis (UC)

[ ] Sarcoidosis

[ ] Chronic severe (i.e., extensive and/or disabling) plaque psoriasis

[ ] Ankylosing Spondylitis

[ ] Moderately to severely active Crohn's Disease (CD)

[ ] Active psoriatic arthritis (PsA)

[ ] Moderately to severely active fistulizing Crohn's Disease (FCD)

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

Q11: Does the member meet any one of the following? (Check only one that apply)

[ ] Frequent diarrhea and abdominal pain, at least 10% weight loss, complications (e.g., obstruction, fever, abdominal mass), abnormal lab values (e.g., CRP) (please specify and provide supporting documents) _____(*Required)

[ ] CD Activity Index (CDAI) greater than 220 (please specify and provide supporting documents)

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

Q12: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (e.g., prednisone), methotrexate? (Check only one that apply)

[ ] Yes (please specify drug name, 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)

Q13: Does the member meet any one of the following? (Check only one that apply)

[ ] Greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (e.g., hemoglobin, ESR, CRP) (please provide the supporting documents) _____ (*Required)

[ ] Refractory to corticosteroids (please provide the supporting documents) _____(*Required)

[ ] Dependent on corticosteroids (please provide the supporting documents) _____(*Required)

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

Q14: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least one of the following conventional therapies: corticosteroids (e.g., prednisone), aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine), azathioprine, 6-mercaptopurine? (Check only one that apply)

[ ] Yes (please specify drug name, 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)

Q15: Is the requested medication used in combination with methotrexate? (Check only one that apply)

[ ] Yes

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

Q16: Does the member meet any one of the following? (Check only one that apply)

[ ] Actively inflamed joints

[ ] Dactylitis

[ ] Enthesitis

[ ] Axial disease

[ ] Active skin and/or nail involvement (please specify) _____ (*Required)

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

Q17: Does the member meet any one of the following? (Check only one that apply)

[ ] At least 3% body surface area (BSA) involvement (please specify) _____(*Required)

[ ] Severe scalp psoriasis

[ ] Palmoplantar (i.e., palms, soles) (please specify) _____ (*Required)

[ ] Facial, or genital involvement (please specify) _____(*Required)

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

Q18: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least 4 weeks trials of one of the following topical therapies: corticosteroids (e.g., betamethasone, clobetasol), vitamin D analogs (e.g., calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), anthralin, OR coal tar? (Check only one that apply)

[ ] Yes (please specify drug name, 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)

Q19: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least a 1 months trial of one NSAID (e.g., ibuprofen, naproxen)? (Check only one that apply)

[ ] Yes (please specify drug name, 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)

Q20: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least to one of the following: corticosteroid (e.g., prednisone) OR immunosuppressant (e.g., methotrexate, cyclophosphamide, azathioprine)? (Check only one that apply)

[ ] Yes (please specify drug name, 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)

Q21: Is the requested drug prescribed by or in consultation with a rheumatologist? (Check only one that apply)

[ ] Yes

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

Q22: Is the requested drug prescribed by or in consultation with a rheumatologist or dermatologist? (Check only one that apply)

[ ] Yes (please specify the specialist) _____(*Required)

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

Q23: Is the requested drug prescribed by or in consultation with a gastroenterologist? (Check only one that apply)

[ ] Yes

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

Q24: Is the requested drug prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist? (Check only one that apply)

[ ] Yes (please specify the specialist) _____(*Required)

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

Q25: Is the requested drug prescribed by or in consultation with a dermatologist? (Check only one that apply)

[ ] Yes

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

Q26: Has the member had an inadequate response or intolerance to Remicade or Infliximab? (Check only one that apply)

[ ] Yes (please specify drug name, 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)

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:	