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):	[ ] Retacrit 10,000 unit/mL injection solution [ ] Retacrit 2,000 unit/mL injection solution [ ] Retacrit 20,000 unit/2 mL injection solution [ ] Retacrit 20,000 unit/mL injection solution [ ] Retacrit 3,000 unit/mL injection solution [ ] Retacrit 4,000 unit/mL injection solution [ ] Retacrit 40,000 unit/mL injection 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)

[ ] Anemia due to chronic kidney disease

[ ] Anemia in HIV infected member

[ ] Anemia in member with Myelodysplastic Syndrome (MDS)

[ ] Anemia due to cancer secondary to chemotherapy

[ ] Anemia in hepatitis C Virus (HCV) infected member due to ribavirin in combination with interferon or peg-interferon

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

Q4: Is the member on dialysis without ESRD (End Stage Renal Disease)? (Check only one that apply)

[ ] Yes

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

Q5: Is the member's most recent or average Hct over 3 months 33% or less (Hgb is 11 g/dL or less)? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q6: Is the member not on dialysis? (Check only one that apply)

[ ] Yes

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

Q7: Is the member's most recent or average Hct over 3 months 30% or less (Hgb 10 g/dL or less)? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q8: Is the request for pediatric member? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request) _____(*Required)

Q9: Is the member's most recent or average Hct over 3 months 36% or less (Hgb 12 g/dL or less)? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q10: Has the member been evaluated for adequate iron stores? (Check only one that apply)

[ ] Yes

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

Q11: Is the member's most recent or average Hct over 3 months below 36% or most recent or avg Hgb over 3 months is below 12 g/dl? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q12: Is the member's most recent or avg Hct over 3 months 36% or less or Hgb over 3 months is 12 g/dl or less? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q13: Is there a decrease in the need for blood transfusion? (Check only one that apply)

[ ] Yes _____(*Required)

[ ] No

Q14: Does the member have documentation supporting 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 medical justification for continuation of therapy) _____(*Required)

Q15: Is the member concurrently on chemotherapy? (Check only one that apply)

[ ] Yes (please provide the start and end date of chemotherapy) _____(*Required)

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

Q16: Does the member have anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) when collected within the prior 2 weeks of request? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q17: Is the member's most recent or avg Hct over 3 months 36% or less? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

[ ] No

Q18: Is the member's most recent or avg Hgb over 3 months 12 g/dl or less? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q19: Is there a decrease in the need for blood transfusion? (Check only one that apply)

[ ] Yes

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

Q20: Does the member have documentation supporting 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 medical justification for continuation of therapy) _____(*Required)

Q21: What is the member's diagnosis? (Check only one that apply)

[ ] Anemia due to Chronic Kidney disease(CKD)

[ ] Anemia in HIV infected member

[ ] Anemia due to cancer secondary to chemotherapy

[ ] Pre-operative use for reduction of allogenic blood transfusion in patients undergoing surgery

[ ] Anemia in hepatitis C Virus (HCV) infected member due to ribavirin in combination with interferon or peg-interferon

[ ] Anemia in member with Myelodysplastic Syndrome (MDS)

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

Q22: Is the member on dialysis? (Check only one that apply)

[ ] Yes

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

Q23: Does the member have ESRD (End stage renal disease)? (Check only one that apply)

[ ] Yes

[ ] No

Q24: Does the rate of hemoglobin decline indicate the likelihood of requiring a red blood cell (RBC) transfusion? (Check only one that apply)

[ ] Yes

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

Q25: Is the goal of therapy to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? (Check only one that apply)

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

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

Q26: Does the member have anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q27: Has the patient been evaluated for adequate iron stores? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q28: Does the member have anemia labs values (Hgb less than 12 g/dL or Hct less than 36%) collected within 30 days of request? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q29: Is the serum erythropoietin level less than or equal to 500 mU/mL? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q30: Is the patient receiving zidovudine therapy? (Check only one that apply)

[ ] Yes

[ ] No

Q31: Does the member have a diagnosis of HIV infection? (Check only one that apply)

[ ] Yes

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

Q32: Has the patient been evaluated for adequate iron stores? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q33: Have all other causes of anemia been ruled out? (Check only one that apply)

[ ] Yes

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

Q34: Does the member have anemia lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q35: Is the cancer a non-myeloid malignancy? (Check only one that apply)

[ ] Yes

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

Q36: Is the member concurrently on chemotherapy? (Check only one that apply)

[ ] Yes (please provide start date and end date of chemotherapy) _____(*Required)

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

Q37: Has the patient been evaluated for adequate iron stores? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q38: Is the member scheduled to undergo elective, non-cardiac, non-vascular surgery? (Check only one that apply)

[ ] Yes (please specify the type and date of surgery) _____ (*Required)

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

Q39: Does the member have hemoglobin (Hgb) greater than 10 to less than or equal to 13 g/dL? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q40: Is the member at high risk for perioperative transfusions? (Check only one that apply)

[ ] Yes

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

Q41: Is the member unwilling or unable to donate autologous blood pre-operatively? (Check only one that apply)

[ ] Yes

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

Q42: Has the patient been evaluated for adequate iron stores? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q43: Does the member have anemia labs (Hct less than 36% or Hgb less than 12 g/dL) collected within 30 days of request? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q44: Is the member receiving ribavirin? (Check only one that apply)

[ ] Yes

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

Q45: Is the member receiving interferon alfa? (Check only one that apply)

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

[ ] No

Q46: Is the member receiving peginterferon alfa? (Check only one that apply)

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

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

Q47: Has the patient been evaluated for adequate iron stores? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q48: Is the serum erythropoietin level less than or equal to 500 mU/mL? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q49: Does the member have transfusion-dependent MDS? (Check only one that apply)

[ ] Yes

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

Q50: Has the patient been evaluated for adequate iron stores? (Check only one that apply)

[ ] Yes (please specify the lab values and date of test) _____ (*Required)

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

Q51: Does the member have Hgb greater than 10 g/dL or Hct greater than 30%? (Check only one that apply)

[ ] Yes (please provide supporting clinical rationale for the requested drug) _____(*Required)

[ ] No

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:	