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):	[ ] Ruxience 10 mg/mL 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)

[ ] Non-Hodgkin's Lymphoma (NHL)

[ ] Chronic Lymphocytic Leukemia (CLL)

[ ] Rheumatoid Arthritis (RA)

[ ] Wegener's Granulomatosis (WG)

[ ] Microscopic Polyangiitis (MPA)

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

Q4: Does the member have any one of the following? (Check only one that apply)

[ ] Follicular, CD20-positive, B-cell non-Hodgkin's lymphoma

[ ] Low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma

[ ] Relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma

[ ] Diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma

[ ] CD-20-positive diffuse large B-cell lymphoma

[ ] Burkitt lymphoma

[ ] Burkitt-like lymphoma

[ ] Mature B-cell acute leukemia

[ ] None of above (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Non-Hodgkin's Lymphoma (NHL)

[ ] Chronic Lymphocytic Leukemia (CLL)

[ ] Rheumatoid Arthritis (RA)

[ ] Wegener's Granulomatosis (WG)

[ ] Microscopic Polyangiitis (MPA)

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

Q6: Does the member have any one of the following? (Check only one that apply)

[ ] Follicular, CD20-positive, B-cell non-Hodgkin's lymphoma

[ ] Low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma

[ ] Relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma

[ ] Diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma

[ ] CD-20-positive diffuse large B-cell lymphoma

[ ] Burkitt lymphoma

[ ] Burkitt-like lymphoma

[ ] Mature B-cell acute leukemia

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

Q7: Will the requested medication be used as first-line treatment in combination with chemotherapy regimens? (Check only one that apply)

[ ] Yes (please provide the detail of chemotherary regimen) _____
(*Required)

[ ] No

Q8: Has the member achieved a complete or partial response to rituximab product in combination with chemotherapy? (Check only one that apply)

[ ] Yes (please provide the detail of chemotherary regimen) _____
(*Required)

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

Q9: Will the request be used as monotherapy for maintenance therapy? (Check only one that apply)

[ ] Yes (please provide the detail of chemotherary regimen) _____
(*Required)

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

Q10: Does the member have stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy? (Check only one that apply)

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

[ ] No

Q11: Has the member achieved a partial or complete response following first-line treatment with CVP chemotherapy? (Check only one that apply)

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

[ ] No

Q12: Will the requested medication be used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens? (Check only one that apply)

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

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

Q13: Was the disease previously untreated and in advanced stage? (Check only one that apply)

[ ] Yes

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

Q14: Is the member at least 6 month old? (Check only one that apply)

[ ] Yes

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

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

[ ] Yes

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

Q16: Is the requested medication used in combination with fludarabine and cyclophosphamide? (Check only one that apply)

[ ] Yes

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

Q17: Is the requested medication in combination with methotrexate? (Check only one that apply)

[ ] Yes

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

Q18: Has the member had an inadequate response, intolerance or experienced contraindication(s) to a TNF antagonist (eg, adalimumab, etanercept, 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)

Q19: Is the member concurrently on glucocorticoids (eg, prednisone)? (Check only one that apply)

[ ] Yes

[ ] No

Q20: Has the member had contraindication(s) or intolerance experienced to glucocorticoids (eg, prednisone)? (Check only one that apply)

[ ] Yes (please specify 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 reqeusted medication prescribed by or in consultation with a hematologist or oncologist? (Check only one that apply)

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

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

Q22: 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)

Q23: Is the reqeusted medication prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist? (Check only one that apply)

[ ] Yes (please specify prescriber 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:	