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):	[ ] Synagis 100 mg intramuscular solution [ ] Synagis 100 mg/mL intramuscular solution [ ] Synagis 50 mg intramuscular solution [ ] Synagis 50 mg/0.5 mL intramuscular 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 Synagis being used for immunoprophylaxis of respiratory syncytial virus (RSV) during the peak months of infection in the member's geographic region? (Check only one that apply)

[ ] Yes

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

Q3: Is the infants born at 28 weeks, six days gestation or earlier? (Check only one that apply)

[ ] Yes

[ ] No

Q4: Is the member younger than 12 months of age at the start of the RSV season? (Check only one that apply)

[ ] Yes

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

Q5: Does the member have diagnosis of chronic lung disease of prematurity, born before 32 weeks, 0 days gestation, received greater than 21% oxygen for at least the first 28 days after birth? (Check only one that apply)

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

[ ] No

Q6: Is the member atleast 12 months of age or younger at the start of the RSV season? (Check only one that apply)

[ ] Yes

[ ] No

Q7: Is the member greater than 12 months of age to 24 months of age at the start of the RSV season? (Check only one that apply)

[ ] Yes

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

Q8: Had the member received medical support (i.e., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season? (Check only one that apply)

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

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

Q9: Is the member 12 months of age or younger at the start of the RSV season? (Check only one that apply)

[ ] Yes

[ ] No

Q10: Does the member have acyanotic heart failure that will require a cardiac surgical procedure and the member is receiving medication to control congestive heart failure? (Check only one that apply)

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

[ ] No

Q11: Does the member have moderate to severe pulmonary hypertension? (Check only one that apply)

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

[ ] No

Q12: Does the member have cyanotic heart defect? (Check only one that apply)

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

[ ] No

Q13: Is the member 24 months of age or younger? (Check only one that apply)

[ ] Yes

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

Q14: Has the member undergone or will undergo a cardiac transplantation during the RSV season? (Check only one that apply)

[ ] Yes

[ ] No

Q15: Is the member 12 months of age or younger? (Check only one that apply)

[ ] Yes

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

Q16: Does the member have congenital abnormality or neuromuscular disorder and has an impaired ability to clear secretions from the upper airway due to an ineffective cough? (Check only one that apply)

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

[ ] No

Q17: Is the member younger than 24 months of age? (Check only one that apply)

[ ] Yes

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

Q18: Does the member have lymphocyte count below the normal range for member's age? (Check only one that apply)

[ ] Yes

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

Q19: Has the member received or will receive a solid organ transplant, hematopoietic stem cell transplant recipient, or chemotherapy during the RSV season? (Check only one that apply)

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

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

Q20: Is the requested drug prescribed by or in consultation with a with a pediatric specialist (i.e., pulmonologist, neonatologist, neurologist, cardiologist, pediatric intensivist, or infectious disease specialist)? (Check only one that apply)

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

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[ ] 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:	