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):	[ ] Tezspire 210 mg/1.91 mL (110 mg/mL) subcutaneous syringe
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – 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

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)

[ ] Severe asthma

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

Q4: Is there documentation the member has had a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1])? (Check only one that apply)

[ ] Yes (please provide document(s) supporting positive response to therapy) _____(*Required)

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

Q5: Has the member had an intolerance or experienced contraindication(s) to inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)? (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)

Q6: Is the requested medication prescribed by or in consultation with an pulmonologist or allergist/immunologist? (Check only one that apply)

[ ] Yes (please provide prescriber's specialty) _____(*Required)

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

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

[ ] Severe asthma

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

Q8: Does the member have a history of two or more asthma exacerbations requiring systemic corticosteroid (e.g., prednisone) treatment within past 12 months? (Check only one that apply)

[ ] Yes

[ ] No

Q9: Does the member have a history of prior asthma-related hospitalization within the past 12 months? (Check only one that apply)

[ ] Yes

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

Q10: Has the member had an intolerance or experienced contraindication(s) to high-dose inhaled corticosteroid (ICS) (i.e., greater than 500 mcg fluticasone propionate equivalent/day) ? (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)

Q11: Has the member had an intolerance or experienced contraindication(s) to additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)? (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)

Q12: Has the member had an intolerance or experienced contraindication(s) to atleast one combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])? (Check only one that apply)

[ ] Yes (please specify atleast one maximally dosed combination drugs 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: Will the medication used to treat eosinophilic asthma? (Check only one that apply)

[ ] Yes

[ ] No

Q14: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least one the following drug (Nucala (mepolizumab), Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab))? (Check only one that apply)

[ ] Yes (please specify at least one 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: Will the medication used to treat oral corticosteroid-dependent asthma? (Check only one that apply)

[ ] Yes

[ ] No

Q16: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Dupixent (dupilumab)? (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)

Q17: Will the medication used to treat persistent allergic asthma? (Check only one that apply)

[ ] Yes

[ ] No

Q18: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Xolair (omalizumab)? (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)

Q19: Is the member at least 12 years old? (Check only one that apply)

[ ] Yes

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

Q20: Is the requested medication prescribed by or in consultation with an pulmonologist or allergist/immunologist? (Check only one that apply)

[ ] Yes (please provide prescriber's 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:	