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):	[ ] Triptodur 22.5 mg intramuscular suspension
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – 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)

[ ] Central Precocious Puberty (idiopathic or neurogenic)

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

Q4: Has the member's luteinizing hormone (LH) levels been suppressed to pre-pubertal levels? (Check only one that apply)

[ ] Yes (please specify luteinizing hormone (LH) levels) _____
(*Required)

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

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

[ ] Central Precocious Puberty (idiopathic or neurogenic)

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

Q6: Does the member have early onset of secondary sexual characteristics in females less than age 8 or males less than age 9? (Check only one that apply)

[ ] Yes (please specify secondary sexual characteristics) _____
(*Required)

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

Q7: Does the member have advanced bone age of at least one year compared with chronologic age? (Check only one that apply)

[ ] Yes

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

Q8: Has the member undergone gonadotropin-releasing hormone agonist (GnRHa) testing and peak luteinizing hormone (LH) level above pre-pubertal range? (Check only one that apply)

[ ] Yes (please provide the test date and test result(s))

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

Q9: Does the member have a random luteinizing hormone (LH) level in the pubertal range? (Check only one that apply)

[ ] Yes (please provide the test date and test result)

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

Q10: Has the member had an inadequate response or intolerance to Lupron Depot-Ped? (Check only one that apply)

[ ] Yes (please specify intolerance experienced and the start and end date(s) of therapy (month/year))
_____(*Required)

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

Q11: Is the reqeusted medication prescribed by or in consultation with a pediatric endocrinologist? (Check only one that apply)

[ ] Yes _____(*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:	