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):	[ ] Tysabri 300 mg/15 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)

[ ] Relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions)

[ ] Crohn's Disease (CD)

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

Q4: Dose the member have documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response)
_____(*Required)

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

Q5: Does the member have documentation of positive clinical response (eg, improved disease activity index) to therapy? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response)
_____(*Required)

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

Q6: Is the requested medication used in combination with an immunosuppressant (eg, 6-MP, azathioprine, cyclosporine, or methotrexate? (Check only one that apply)

[ ] Yes (please provide medical justification for continuation of therapy)
_____(*Required)

[ ] No

Q7: Is the requested medication used in combination with a TNF-inhibitor (eg, Enbrel [etanercept], Humira [adalimumab], or infliximab)? (Check only one that apply)

[ ] Yes (please provide medical justification for continuation of therapy)
_____(*Required)

[ ] No

Q8: Is the member on Steroid? (Check only one that apply)

[ ] Yes

[ ] No

Q9: What is the member's diagnosis? (Check only one that apply)

[ ] Relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions)

[ ] Crohn's Disease (CD)

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

Q10: Has the member had an inadequate response, intolerance or experienced contraindication(s) to one of the following disease-modifying therapies for MS (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year))? (Check only one that apply)

[ ] Aubagio (teriflunomide) _____(*Required)

[ ] Lemtrada (alemtuzumab _____(*Required)

[ ] Mavenclad (cladribine) _____(*Required)

[ ] Plegridy (peginterferon beta-1a) _____(*Required)

[ ] Any one of the inteferon beta-1a injections (eg, Avonex) _____ (*Required)

[ ] Any one of the interferon beta-1b injections (eg, Betaseron, Extavia) _____(*Required)

[ ] Any one of the glatiramer acetate injections (eg, Copaxone, Glatopa, generic glatiramer acetate) _____(*Required)

[ ] Any one of the oral fumarates (eg, brand Tecfidera, generic dimethyl fumarate) _____(*Required)

[ ] Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (eg, Gilenya, Mayzent, Zeposia) _____(*Required)

[ ] Any one of the B-cell targeted therapies (eg, Ocrevus, Kesimpta) _____(*Required)

[ ] No

Q11: Is the member a candidate for any of the drugs listed as prerequisites due to the severity of their MS? (Check only one that apply)

[ ] Yes

[ ] No

Q12: Is the request for continuation of prior therapy? (Check only one that apply)

[ ] Yes

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

Q13: Is the requested medication used in combination with another disease-modifying therapy for MS? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____ (*Required)

[ ] No

Q14: Is the requseted medication prescribed by or in consultation with a neurologist? (Check only one that apply)

[ ] Yes

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

Q15: Does the member have diagnosis of moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes)? (Check only one that apply)

[ ] Yes (please specify evidence of inflammation) _____(*Required)

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

Q16: Has the member had an inadequate response, intolerance or experienced contraindication(s) to one of the following conventional therapies: corticosteroids (eg, prednisone, methylprednisolone), 6-mercaptopurine (6MP [Purinethol], azathioprine (Imuran), methotrexate (Rheumatrex, Trexall), aminosalicylates (eg, sulfasalazine, mesalamine, olsalazine)? (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)

Q17: Has the member had an inadequate response, intolerance or experienced contraindication(s) to a TNF-inhibitor (eg, Humira [adalimumab], 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)

Q18: Is the requested medication used in combination with an immunosuppressant (eg, 6-MP, azathioprine, cyclosporine, or methotrexate? (Check only one that apply)

[ ] Yes (please provide medical justification for continuation of therapy) _____(*Required)

[ ] No

Q19: Is the requested medication used in combination with a TNF-inhibitor (eg, Enbrel [etanercept], Humira [adalimumab], or infliximab)? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____ (*Required)

[ ] No

Q20: Is the requested medication prescribed by or in consultation with a gastroenterologist? (Check only one that apply)

[ ] Yes

[ ] 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:	