

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):	<input type="checkbox"/> Ubrelvy 100 mg tablet <input type="checkbox"/> Ubrelvy 50 mg tablet
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)

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Migraine with or without aura

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

Q4: Has the member experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)?
(Check only one that apply)

Yes (please provide documentation of positive clinical response to therapy)
_____ (*Required)

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

Q5: Is the request for preventive treatment of migraine? (Check only one that apply)

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

No

Q6: Will the requested medication be used in combination with another oral CGRP inhibitor? (Check only one that apply)

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

No

Q7: Does the medication prescribed by or in consultation with neurologist, headache specialist, or pain specialist? (Check only one that apply)

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

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

Q8: What is the member's diagnosis? (Check only one that apply)

Migraine with or without aura

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

Q9: Is the request for treatment of acute migraine? (Check only one that apply)

Yes

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

Q10: Is the request for preventive treatment of migraine? (Check only one that apply)

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

No

Q11: Does the member has less than 15 headache days per month? (Check only one that apply)

Yes (please specify number of headache days per month) _____
(*Required)

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[] No (please specify number of headache days per month and please provide clinical rationale for the request) _____ (*Required)

Q12: Has the member had an inadequate response, or intolerance to one of the following triptan (e.g., eletriptan, rizatriptan, sumatriptan)? (Check only one that apply)

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

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

Q13: Has the member had an contraindication(s) to all class of triptans (e.g., eletriptan, rizatriptan, sumatriptan)? (Check only one that apply)

[] Yes (please specify drug name(s), and corresponding contraindication(s) experienced, and the start and end date(s) of therapy (month/year)) _____ (*Required)

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

Q14: Will the request be used in combination with another oral CGRP inhibitor? (Check only one that apply)

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

[] No

Q15: Is the member at least 18 years old? (Check only one that apply)

[] Yes (please specify member's age) _____ (*Required)

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

Q16: Does the medication prescribed by or in consultation with neurologist, headache specialist, or pain specialist? (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: