

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):  | [ ] Vabysmo 6 mg/0.05 mL intravitreal 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.<br>Please include any relevant test results<br>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)

Prior Authorization Form

No

Q3: What is the member's diagnosis? (Check only one that apply)

Neovascular (wet) age-related macular degeneration (nAMD)

Diabetic macular edema (DME)

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

Q4: Does the member have documentation of positive clinical response to therapy (e.g., Improvement in Best Corrected Visual Acuity (BCVA) compared to baseline, stable vision)? (Check only one that apply)

Yes (please provide the supporting documents) \_\_\_\_\_  
 (\*Required)

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

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

Neovascular (wet) age-related macular degeneration (nAMD)

Diabetic macular edema (DME)

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

Q6: Has the member had an inadequate response, intolerance or experienced contraindication(s) to compounded bevacizumab prepared by a 503(B) Outsourcing Facility OR Lucentis (ranibizumab)? (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)

Q7: Is the requested medication prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases? (Check only one that apply)

Yes (please provide prescriber specialty)

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

|   |              |
|---|--------------|
| <p><b>Attestation:</b> 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.</p> |              |
| <p>Signature of Prescriber or Authorized Representative:</p>  | <p>Date:</p> |
| <p>Print Authorized Representative Name:</p>  |              |