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):	[ ] Venclexta Starting Pack 10 mg-50 mg-100 mg tablets in a dose pack
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)

[ ] Chronic lymphocytic leukemia (CLL)

[ ] Small lymphocytic lymphoma (SLL)

[ ] Acute Myeloid Leukemia (AML)

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

Q4: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic lymphocytic leukemia (CLL)

[ ] Small lymphocytic lymphoma (SLL)

[ ] Newly diagnosed Acute myeloid leukemia (AML)

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

Q5: Will the medication be used in combination with azacitidine, or decitabine, or low-dose cytarabine? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

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

Q6: Is the member at least 75 years old? (Check only one that apply)

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

[ ] No

Q7: Does the member have comorbidities that preclude use of intensive induction chemotherapy? (Check only one that apply)

[ ] Yes (please specify comorbodities) _____(*Required)

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

Q8: Does the medication prescribed by or in consultation with a hematologist or oncologist? (Check only one that apply)

[ ] Yes (please provide 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:	