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):	[ ] Xembify 1 gram/5 mL (20 %) subcutaneous solution [ ] Xembify 10 gram/50 mL (20 %) subcutaneous solution [ ] Xembify 2 gram/10 mL (20 %) subcutaneous solution [ ] Xembify 4 gram/20 mL (20 %) subcutaneous 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: Does the member have a diagnosis of primary immune deficiency disease? (Check only one that apply)

[ ] Yes

[ ] No

Q3: Is the requested drug administered in the home? (Check only one that apply)

[ ] Yes

[ ] No

Q4: Does the member have provider determination that administration in the home is medically appropriate? (Check only one that apply)

[ ] Yes

[ ] No

Q5: Request is for the treatment of which of following autoimmune mucocutaneous blistering diseases? (Check only one that apply)

[ ] Biopsy-proven pemphigus vulgaris

[ ] None of the above (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

[ ] Pemphigus foliaceus

[ ] Bullous phemphigoid

[ ] Mucous membrane pemphigoid (a.k.a., cicatricial pemphigoid)

[ ] Epidermolysis bullosa acquisita

Q6: 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

Q7: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic inflammatory demyelinating polyneuropathy (CIDP)

[ ] Common variable immunodeficiency (CVID),

[ ] Congenital agammaglobulinemia (X-linked or autosomal recessive)

[ ] Severe combined immunodeficiencies (SCID)

[ ] Wiskott-Aldrich syndrome

[ ] Other primary immunodeficiency with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis.

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

Q8: Does the member lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine)? (Check only one that apply)

[ ] Yes

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

Q9: Does the member have experienced an objective improvement on immune globulin therapy? (Check only one that apply)

[ ] Yes

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

Q10: Member meets which one of the following minimum effective dose for maintenance therapy? (Check only one that apply)

[ ] By decreasing the frequency of dose

[ ] By increasing the frequency of dose

[ ] By implementing both strategies

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

Q11: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic inflammatory demyelinating polyneuropathy (CIDP)

[ ] Common variable immunodeficiency (CVID),

[ ] Congenital agammaglobulinemia (X-linked or autosomal recessive

[ ] Severe combined immunodeficiencies (SCID)

[ ] Wiskott-Aldrich syndrome

[ ] Other primary immunodeficiency with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis

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

Q12: Does the member lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine)? (Check only one that apply)

[ ] Yes

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

Q13: Will the request be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis? (Check only one that apply)

[ ] Yes

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

Q14: Is the requested medication being used subcutaneously? (Check only one that apply)

[ ] Yes

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

Q15: Is the requested medication prescribed by or in consultation with a physician who has specialized expertise in managing patients on SCIG therapy (e.g., immunologist, hematologist, neurologist)? (Check only one that apply)

[ ] Yes (please specify prescriber specialty)

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

Q16: Does the member have contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication)? (Check only one that apply)

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

[ ] No _____(*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:	