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):	[ ] Xolair 150 mg subcutaneous solution [ ] Xolair 150 mg/mL subcutaneous syringe [ ] Xolair 75 mg subcutaneous solution [ ] Xolair 75 mg/0.5 mL subcutaneous syringe
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)

[ ] Moderate to severe persistent allergic asthma

[ ] Chronic Idiopathic Urticaria (CIU)

[ ] Nasal polyps (NP)

[ ] 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., Reduction in asthma exacerbations, improvement in forced expiratory volume in 1 second (FEV1), decreased use of rescue medications)? (Check only one that apply)

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

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

Q5: Does the member continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) unless there is a contraindication or intolerance to these medications? (Check only one that apply)

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

[ ] No

Q6: Is the member currently being treated with additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications? (Check only one that apply)

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

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

Q7: Is the requested medication prescribed by or in consultation with an otolaryngologist, allergist/immunologist, or pulmonologist? (Check only one that apply)

[ ] Yes (please specify prescriber(s) specialty) _____(*Required)

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

Q8: Has the member's disease status been re-evaluated since the last authorization to confirm the member's condition warrants continued treatment? (Check only one that apply)

[ ] Yes

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

Q9: Has the member experienced a reduction in itching severity from baseline? (Check only one that apply)

[ ] Yes

[ ] No

Q10: Has the member experienced a reduction in the number of hives from baseline? (Check only one that apply)

[ ] Yes

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

Q11: Does the member have documentation of a positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS: 0-8 scale], improvement in nasal congestion/obstruction score [NCS: 0-3 scale])? (Check only one that apply)

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

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

Q12: Does the prescribed medication used in combination with another agent for nasal polyps? (Check only one that apply)

[ ] Yes

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

Q13: What is the member's diagnosis? (Check only one that apply)

[ ] Moderate to severe persistent allergic asthma

[ ] Chronic Idiopathic Urticaria (CIU)

[ ] Nasal polyps (NP)

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

Q14: Does the member have positive skin test or in vitro reactivity to a perennial aeroallergen? (Check only one that apply)

[ ] Yes

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

Q15: Does the member have pre-treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL for patients 12 years of age and older? (Check only one that apply)

[ ] Yes (please specify the serum immunoglobulin (Ig)E level) _____ (*Required)

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

Q16: Does the member have pre-treatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL for patients 6 years to less than 12 years of age? (Check only one that apply)

[ ] Yes (please specify the serum immunoglobulin (Ig)E level and the member's age) _____(*Required)

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

Q17: Does the member continues to be treated with a high-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day] unless there is a contraindication or intolerance to these medications? (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

Q18: Is the member currently being treated with additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications? (Check only one that apply)

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

[ ] No

Q19: Is the member currently being treated one max-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone/vilanterol)] unless there is a contraindication or intolerance to these medications? (Check only one that apply)

[ ] Yes (please specify drug name(s), 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)

Q20: Is the requested medication prescribed by or in consultation with an otolaryngologist, allergist/immunologist, or pulmonologist? (Check only one that apply)

[ ] Yes (please specify prescriber(s) specialty) _____(*Required)

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

Q21: Does the member have persistent symptoms (itching and hives) with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines? (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

Q22: Has the member had an inadequate response or experienced contraindication(s) to at least one of the following additional therapies: H2 antagonist (e.g., famotidine, cimetidine), leukotriene receptor antagonist (e.g., montelukast), H1 antihistamine, hydroxyzine, doxepin? (Check only one that apply)

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

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

Q23: Is the requested medication used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines? (Check only one that apply)

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

[ ] No

Q24: Is the requested medication prescribed by or in consultation with an allergist/immunologist, or dermatologist? (Check only one that apply)

[ ] Yes (please specify prescriber(s) specialty) _____(*Required)

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

Q25: Has the member had an inadequate response or experienced contraindication(s) with an intranasal corticosteroid (e.g., fluticasone, mometasone)? (Check only one that apply)

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

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

Q26: Is the requested medication being used in combination with another with nasal polyposis agent? (Check only one that apply)

[ ] Yes

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

Q27: Is the requested medication prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist? (Check only one that apply)

[ ] Yes (please specify prescriber(s) 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:	