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):	[ ] Zeposia Starter Kit 0.23 mg-0.46 mg-0.92 mg capsules in a dose pack
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)

[ ] Relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) (please specify) _____ (*Required)

[ ] Moderately to severely active Ulcerative colitis (UC)

[ ] 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., stability in radiologic disease activity, clinical relapses, disease progression)? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

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

Q5: Does the member have documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

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

Q6: What is the member's diagnosis? (Check only one that apply)

[ ] Relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) (please specify) _____ (*Required)

[ ] Moderately to severely active Ulcerative colitis (UC)

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

Q7: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least 4 weeks trial of two of the following disease-modifying therapies for MS: Aubagio (teriflunomide), Gilenya (fingolimod), or Brand Tecfidera/generic dimethyl fumarate? (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

Q8: Is the request for continuation of prior therapy? (Check only one that apply)

[ ] Yes

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

Q9: Is the requested medication prescribed by or in consultation with a neurologist? (Check only one that apply)

[ ] Yes _____(*Required)

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

Q10: Member's diagnosis is supported by any one of the following: (Check only one that apply)

[ ] Greater than 6 stools per day

[ ] Frequent blood in the stools

[ ] Frequent urgency

[ ] Presence of ulcers

[ ] Abnormal lab values (e.g., hemoglobin, ESR, CRP)

[ ] Dependent on corticosteroids

[ ] Refractory to corticosteroids

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

Q11: Has the member had an inadequate response, contraindication(s) or have intolerance to two of the following: Humira (adalimumab), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz IR (tofacitinib IR)/Xeljanz XR (tofacitinib XR)? (Check only one that apply)

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

[ ] No (please provide medical justification for the request) _____ (*Required)

Q12: Is the request for continuation of prior therapy? (Check only one that apply)

[ ] Yes

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

Q13: Is the requested medication prescribed by or in consultation with a gastroenterologist? (Check only one that apply)

[ ] Yes

[ ] 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:	