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):	[ ] Zirabev 25 mg/mL intravenous 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: 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)

[ ] Metastatic colorectal cancer

[ ] Non-Small Cell Lung Cancer

[ ] Metastatic renal cell cancer

[ ] Carcinoma of the cervix

[ ] Recurrent glioblastoma

[ ] Epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer

[ ] Hepatocellular carcinoma

[ ] 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)

[ ] Metastatic colorectal cancer

[ ] Non-Small Cell Lung Cancer

[ ] Metastatic renal cell cancer

[ ] Carcinoma of the cervix

[ ] Recurrent glioblastoma

[ ] Epithelial ovarian cancer

[ ] Hepatocellular carcinoma

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

[ ] Fallopian tube cancer

[ ] Primary peritoneal cancer

Q5: Will the requested drug be used as first- or second-line treatment? (Check only one that apply)

[ ] Yes (please specify applicable line of treatment) _____
(*Required)

[ ] No

Q6: Will the requested drug be used in combination with an intravenous 5-fluorouracil-based chemotherapy? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____
(*Required)

[ ] No

Q7: Will the requested drug be used as second-line treatment? (Check only one that apply)

[ ] Yes

[ ] No _____(*Required)

Q8: Will the requested drug be used in combination with fluoropyrimidine-irinotecan-based chemotherapy or fluoropyrimidine-oxaliplatin-based chemotherapy? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

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

Q9: Does the member have progressed on a first-line bevacizumab-containing regimen? (Check only one that apply)

[ ] Yes

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

Q10: Does the member have squamous cell histology? (Check only one that apply)

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

[ ] No

Q11: Is member's disease unresectable, locally advanced, recurrent, or metastatic? (Check only one that apply)

[ ] Yes (please specify type of disease) _____(*Required)

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

Q12: Will the requested drug be used as first-line treatment? (Check only one that apply)

[ ] Yes

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

Q13: Will the requested drug be used in combination with paclitaxel and carboplatin? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

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

Q14: Will the requested drug be used in combination with interferon-alpha? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

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

Q15: Is member's disease is persistent, recurrent, or metastatic? (Check only one that apply)

[ ] Yes (please specify type of disease) _____(*Required)

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

Q16: Will the requested drug be used in combination with paclitaxel and cisplatin? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

[ ] No _____(*Required)

Q17: Will the requested drug be used in combination with paclitaxel and topotecan? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

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

Q18: Is member's disease stage 3 or 4? (Check only one that apply)

[ ] Yes (please specify disease stage) _____(*Required)

[ ] No

Q19: Has the member been treated with bevacizumab as a single agent? (Check only one that apply)

[ ] Yes (please specify start date of therapy (dd/mm/yy)) _____ (*Required)

[ ] No

Q20: Is the member's treatment following surgical resection? (Check only one that apply)

[ ] Yes

[ ] No

Q21: Will the requested drug be used in combination with carboplatin and paclitaxel? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

[ ] No

Q22: Is member's disease platinum-resistant recurrent? (Check only one that apply)

[ ] Yes

[ ] No

Q23: Has the member received not more than 2 prior chemotherapy regimens? (Check only one that apply)

[ ] Yes (please specify name(s) of chemotherapy regimens and start and end date of therapy (mm/yy))
_____(*Required)

[ ] No

Q24: Will the requested drug be used in combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

[ ] No

Q25: Is member's disease platinum-sensitive recurrent? (Check only one that apply)

[ ] Yes

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

Q26: Has the member been treated with bevacizumab as a single agent? (Check only one that apply)

[ ] Yes (please specify start date of therapy (dd/mm/yy)) _____ (*Required)

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

Q27: Does the requested drug used in combination with carboplatin and paclitaxel? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

[ ] No

Q28: Will the requested drug be used in combination with carboplatin and gemcitabine? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

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

Q29: Is member's disease unresectable or metastatic? (Check only one that apply)

[ ] Yes (please specify type of disease) _____(*Required)

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

Q30: Will the requested drug be used in combination with Tecentriq (atezolizumab)? (Check only one that apply)

[ ] Yes (please specify the combination therapy details) _____ (*Required)

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

Q31: Has the member received prior systemic therapy? (Check only one that apply)

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

[ ] No

Q32: Is the medication prescribed by or in consultation with an oncologist? (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.

Prior Authorization Form

Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	