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):	[ ] Zokinvy 50 mg capsule [ ] Zokinvy 75 mg capsule
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – 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: What is the member's diagnosis? (Check only one that apply)

[ ] Hutchinson-Gilford Progeria Syndrome

[ ] Treatment of processing deficient Progeroid Laminopathies

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

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Q3: Does the member have Heterozygous LMNA mutation with progerin-like protein accumulation? (Check only one that apply)

[ ] Yes

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

Q4: Does the member have Homozygous or compound heterozygous ZMPSTE24 mutations? (Check only one that apply)

[ ] Yes(please specify the mutation type) _____(*Required)

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

Q5: Is the has a body surface area of 0.39 m^2 and above? (Check only one that apply)

[ ] Yes (please specify the body surface area) _____(*Required)

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

Q6: Is the member 12 months of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age) _____(*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:	