

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):	<input type="checkbox"/> Zoladex 10.8 mg subcutaneous implant <input type="checkbox"/> Zoladex 3.6 mg subcutaneous implant
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: 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)

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Advance prostate Cancer

Metastatic prostate cancer

Endometriosis

Advanced Breast Cancer

Endometrial thinning

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)

Advance prostate Cancer

Metastatic prostate cancer

Endometriosis

Advanced Breast Cancer

Endometrial thinning

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

Q5: Has the member had an inadequate response, contraindication or intolerance to any brand Lupron formulation? (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 clinical rationale for the request) _____ (*Required)

Q6: Is the requested medication used for the palliative treatment of advanced breast cancer? (Check only one that apply)

Yes

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

Q7: Is the request for Zoladex (3.6 mg strength)? (Check only one that apply)

Yes

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

Q8: Has the member had an inadequate response to Lupron Depot (3.75 mg or 11.25 mg)? (Check only one that apply)

Yes (please the start and end date(s) of therapy (month/year))
_____ (*Required)

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

Q9: Is the member 18 years of age or older? (Check only one that apply)

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Yes

No (please specify member's age) _____ (*Required)

Q10: Is the requested medication used for the treatment of dysfunctional uterine bleeding? (Check only one that apply)

Yes

No (please provide clinical rationale for the request) _____

(*Required)

Q11: Is the requested medication used as an endometrial thinning agent prior to endometrial ablation? (Check only one that apply)

Yes

No (please provide clinical rationale for the request) _____

(*Required)

Q12: Is the request for Zoladex (3.6 mg strength)? (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:	