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):	[ ] ciclopirox 0.77 % topical cream [ ] ciclopirox 0.77 % topical gel [ ] ciclopirox 0.77 % topical suspension [ ] ciclopirox 1 % shampoo [ ] ciclopirox 8 % topical 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: What is the member's diagnosis? (Check only one that apply)

[ ] Onychomycosis of the toenails

[ ] Onychomycosis of the fingernails

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

Q3: Dose the member have mild to moderate disease involving at least 1 target toenail? (Check only one that apply)

[ ] Yes

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

Q4: Has the member had an inadequate response, intolerance or contraindication(s) to oral terbinafine used for at least 12 weeks? (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 (please provide clinical rationale for the request) _____ (*Required)

Q5: Has the diagnosis of onychomycosis been confirmed by one of the following? (Check only one that apply)

[ ] Positive potassium hydroxide (KOH) preparation (please specify lab values and date of lab test (month/year)) _____(*Required)

[ ] Culture (please specify lab values and date of lab test (month/year)) _____(*Required)

[ ] Histology (please specify lab values and date of lab test (month/year)) _____(*Required)

[ ] No (please specify lab test, lab values and date of lab test (month/year)) _____(*Required)

Q6: Does the member have lunula (matrix) involvement? (Check only one that apply)

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

[ ] No

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:	