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):	[ ] dronabinol 10 mg capsule [ ] dronabinol 2.5 mg capsule [ ] dronabinol 5 mg capsule
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 request for the treatment of nausea secondary to cancer treatment or chemotherapy? (Check only one that apply)

[ ] Yes

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

Q3: 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

Q4: Will the requested medication be administered within 48 hours of the cancer treatment as a full replacement to the IV treatment? (Check only one that apply)

[ ] Yes (Please specify dose) _____(*Required)

[ ] No

Q5: Does the member have a prescriber attestation on prescription that the oral anti-nausea drug is being used "as a full therapeutic replacement for an IV anti-nausea drug as part of a cancer chemotherapeutic regimen"? (Check only one that apply)

[ ] Yes (please provide prescription with prescriber attestation) _____(*Required)

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

Q6: Is the requested medication for the treatment of conditions other than the effects of cancer treatment? (Check only one that apply)

[ ] Yes

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

Q7: What is the member's diagnosis? (Check only one that apply)

[ ] Nausea and Vomiting Associated with Cancer Chemotherapy (CINV)

[ ] Anorexia with weight loss in patients with acquired immune deficiency syndrome (AIDS)

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

Q8: Is the member currently on cancer chemotherapy? (Check only one that apply)

[ ] Yes (please specify the chemotherapy regimen and start date) _____(*Required)

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

Q9: Has the member had an inadequate response, contraindication, or intolerance to one 5HT-3 receptor antagonist (e.g., Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron])? (Check only one that apply)

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

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

Q10: Has the member had an inadequate response, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine)? (Check only one that apply)

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

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

Q11: Is the member on antiretroviral therapy? (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:	