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):	[ ] fentanyl 1,200 mcg lozenge on a handle [ ] fentanyl 1,600 mcg lozenge on a handle [ ] fentanyl 100 mcg buccal tablet, effervescent [ ] fentanyl 200 mcg buccal tablet, effervescent [ ] fentanyl 200 mcg lozenge on a handle [ ] fentanyl 400 mcg buccal tablet, effervescent [ ] fentanyl 400 mcg lozenge on a handle [ ] fentanyl 600 mcg buccal tablet, effervescent [ ] fentanyl 600 mcg lozenge on a handle [ ] fentanyl 800 mcg buccal tablet, effervescent [ ] fentanyl 800 mcg lozenge on a handle
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

Prior Authorization Form

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: Is the medication prescribed for the management of breakthrough cancer pain? (Check only one that apply)

[ ] Yes

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

Q4: Is the member currently taking a long-acting opioid around the clock for cancer pain? (Check only one that apply)

[ ] Yes (please specify drug(s) name with strengths and frequency of administration) _____(*Required)

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

Q5: Does the member have at least a one week history of one of the following medications to demonstrate tolerance to opioids? (Check only one that apply)

[ ] Morphine sulfate at doses of greater than or equal to 60 mg/day

[ ] Fentanyl transdermal patch at doses greater than or equal to 25 mcg/hr

[ ] Oxycodone at a dose of greater than or equal to 30 mg/day

[ ] Oral hydromorphone at a dose of greater than or equal to 8 mg/day

[ ] Oral oxymorphone at a dose of greater than or equal to 25 mg/day

[ ] An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day)

[ ] None of the above (please provide clinical rationale for the request) _____(*Required)

Q6: Is the requested medication prescribed by or in consultation with one of the following: Pain specialist, Oncologist, Hematologist, Hospice care specialist, or Palliative care specialist? (Check only one that apply)

[ ] Yes (please specify prescriber(s) specialty) _____(*Required)

[ ] 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:	