

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"/> lenalidomide 10 mg capsule <input type="checkbox"/> lenalidomide 15 mg capsule <input type="checkbox"/> lenalidomide 2.5 mg capsule <input type="checkbox"/> lenalidomide 20 mg capsule <input type="checkbox"/> lenalidomide 25 mg capsule <input type="checkbox"/> lenalidomide 5 mg capsule
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: Is the member currently treated with this medication? (Check only one that apply)

Yes (please list start date of therapy (month/day/year)) \_\_\_\_\_

(\*Required)

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No

Q3: What is the member's diagnosis? (Check only one that apply)

Multiple myeloma

Myelodysplastic syndromes

Mantle cell lymphoma

Follicular lymphoma

Marginal zone lymphoma

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)

Multiple myeloma

Myelodysplastic syndromes

Mantle cell lymphoma

Previously treated follicular lymphoma

Previously treated marginal zone lymphoma

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

\_\_\_\_\_ (\*Required)

Q5: Is the requested medication will be used in combination with dexamethasone? (Check only one that apply)

Yes

No (please explain) \_\_\_\_\_ (\*Required)

Q6: Is the requested medication will be used as a maintenance therapy following autologous hematopoietic stem cell transplantation (auto-HSCT)? (Check only one that apply)

Yes

No (please explain) \_\_\_\_\_ (\*Required)

Q7: Does the member has transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q? (Check only one that apply)

Yes

No (please provide clinical rationale for the request) \_\_\_\_\_

(\*Required)

Q8: Has the disease relapsed after, is refractory to, or progressed after at least one prior therapy (eg, bortezomib, bendamustine, cladribine, rituximab)? (Check only one that apply)

Yes (please specify the tried and failed therapy and start & end dates of therapy)

\_\_\_\_\_ (\*Required)

No (please explain if the member cannot try any therapy) \_\_\_\_\_

(\*Required)

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Q9: Will the requested medication be used in combination with a rituximab product? (Check only one that apply)

Yes

No (please explain if member cannot use rituximab) \_\_\_\_\_

(\*Required)

Q10: Is the requested medication prescribed by or in consultation with an oncologist or a hematologist? (Check only one that apply)

Yes (please provide the prescriber specialty) \_\_\_\_\_ (\*Required)

No (please provide the prescriber specialty) \_\_\_\_\_ (\*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: