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): | [ ] lidocaine 2 % mucosal jelly in applicator [ ] lidocaine HCl 0.5 mg intradermal pen injector [ ] lidocaine HCl 10 mg/mL (1 %) injection solution [ ] lidocaine HCl 10 mg/mL (1 %) injection syringe [ ] lidocaine HCl 10 mg/mL (1 %) intravenous syringe [ ] lidocaine HCl 100 mg/10 mL (1 %) injection syringe [ ] lidocaine HCl 100 mg/5 mL (2 %) injection syringe [ ] lidocaine HCl 2 % mucosal jelly [ ] lidocaine HCl 2 % mucosal solution [ ] lidocaine HCl 20 mg/mL (2 %) injection solution [ ] lidocaine HCl 20 mg/mL (2 %) injection syringe [ ] lidocaine HCl 20 mg/mL (2 %) intravenous syringe [ ] lidocaine HCl 200 mg/mL (20 %) intravenous syringe [ ] lidocaine HCl 3 % lotion [ ] lidocaine HCl 3 % topical cream [ ] lidocaine HCl 3.88 % topical cream [ ] lidocaine HCl 30 mg/3 mL (1%) injection syringe [ ] lidocaine HCl 4 % (40 mg/mL) mucosal solution [ ] lidocaine HCl 4 % laryngotracheal solution [ ] lidocaine HCl 4 % topical cream [ ] lidocaine HCl 4 % topical liquid roll-on [ ] lidocaine HCl 40 mg/mL (4 %) intravenous solution [ ] lidocaine HCl 40 mg/mL (4 %) intravenous syringe [ ] lidocaine HCl 5 % mucosal ointment [ ] lidocaine HCl 5 % topical ointment [ ] lidocaine HCl 5 mg/mL (0.5 %) injection solution [ ] lidocaine HCl 50 mg/5 mL (1 %) injection syringe [ ] lidocaine HCl 60 mg/3 mL (2 %) injection syringe |
| 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: Will the requested drug be used for the treatment of FDA- approved condition (e.g, pain associated with post-herpetic neuralgia, etc)? (Check only one that apply)

[ ] Yes (please specify member's FDA approved diagnosis) _____ (*Required)

[ ] No

Q4: Will the requested drug be used for the treatment of off-lable condition and the off-label guideline approval criteria have been met? (Check only one that apply)

[ ] Yes (please specify member's diagnosis) _____(*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: | |