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):	[ ] megestrol 20 mg tablet [ ] megestrol 40 mg tablet [ ] megestrol 400 mg/10 mL (10 mL) oral suspension [ ] megestrol 400 mg/10 mL (40 mg/mL) oral suspension [ ] megestrol 625 mg/5 mL (125 mg/mL) oral suspension [ ] megestrol 800 mg/20 mL (20 mL) oral suspension
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 65 years of age or older? (Check only one that apply)

[ ] Yes (please specify member's age) _____(*Required)

[ ] No (please specify member's age) _____(*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 drug be used for the treatment of FDA- approved diagnosis (e.g, palliative treatment of advanced breast cancer (recurrent, inoperable, or metastatic); palliative treatment of advanced endometrial carcinoma (recurrent, inoperable, or metastatic) etc)? (Check only one that apply)

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

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

Q5: Has the prescribing physician being made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older)? (Check only one that apply)

[ ] Yes (please provide supporting document(s)) _____(*Required)

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

Q6: Does the prescribing physician wishes to proceed with the originally prescribed medication? (Check only one that apply)

[ ] Yes (please provide supporting document(s)) _____(*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:	