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):	[ ] octreotide acetate 1,000 mcg/mL injection solution [ ] octreotide acetate 100 mcg/mL (1 mL) injection syringe [ ] octreotide acetate 100 mcg/mL injection solution [ ] octreotide acetate 200 mcg/mL injection solution [ ] octreotide acetate 50 mcg/mL (1 mL) injection syringe [ ] octreotide acetate 50 mcg/mL injection solution [ ] octreotide acetate 500 mcg/mL (1 mL) injection syringe [ ] octreotide acetate 500 mcg/mL injection solution
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)

[ ] No

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

[ ] Acromegaly

[ ] Metastatic Carcinoid tumor

[ ] Vasoactive intestinal peptide tumor

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

Q4: Does the member have documentation of positive clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size)? (Check only one that apply)

[ ] Yes (please provide document(s) supporting positive response to therapy)
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: Does the member have improvement in number of diarrhea or flushing episodes? (Check only one that apply)

[ ] Yes

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q6: Does the member have improvement in number of diarrhea episodes? (Check only one that apply)

[ ] Yes

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

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

[ ] Acromegaly

[ ] Metastatic Carcinoid tumor

[ ] Vasoactive intestinal peptide tumor

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

Q8: Does the member have inadequate response to surgical resection and/or pituitary irradiation? (Check only one that apply)

[ ] Yes (please specify name of the procedure, corresponding inadequate response and date of procedure)
_____(*Required)

[ ] No

Q9: Is the member not a candidate for surgical resection or pituitary irradiation? (Check only one that apply)

[ ] Yes

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

Q10: Has the member had an inadequate response, intolerance or experienced contraindication(s) to a dopamine agonist (e.g., bromocriptine or cabergoline)? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) 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: Does the member's diagnosis require symptomatic treatment of severe diarrhea or flushing episodes? (Check only one that apply)

[ ] Yes

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

Q12: Does the member's diagnosis require treatment of profuse watery diarrhea? (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:	