TRICARE Prior Authorization Request Form for
bumetanide nasal spray (Enbumyst)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire. Until complete exclusion status.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Provider acknowledges that Enbumyst will be completely excluded from the TRICARE pharmacy benefit 120 days after the signing of the P&T Committee meeting minutes by the Director, DHA.	☐ **Acknowledged** Proceed to question **2**	
2. Provider acknowledges that other loop diuretics are available to TRICARE beneficiaries, including bumetanide tablets, furosemide tablets, and torsemide and do not require prior authorization.	☐ **Acknowledged** Proceed to question **3**	
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **Stop** **Coverage not approved**
4. Does the patient have edema associated with congestive heart failure, hepatic and renal disease, including nephrotic syndrome?	☐ Yes Proceed to question **5**	☐ No **Stop** **Coverage not approved**
5. Is the patient experiencing an increase in signs and symptoms of fluid overload?	☐ Yes Proceed to question **6**	☐ No **Stop** **Coverage not approved**
6. Has the patient failed a trial of TWO oral loop diuretics including the following: (a) furosemide, (b) bumetanide, (c) torsemide, (d) ethacrynic acid?	☐ Yes Proceed to question **7**	☐ No **Stop** **Coverage not approved**

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7. Does the patient have rhinitis, nasal congestion, OR nasal structural abnormalities?	☐ Yes **Stop** **Coverage not approved**	☐ No Proceed to question **8**
8. Is the patient stable and DOES NOT require emergency care or hospitalization for heart failure, acute pulmonary edema or other condition that could result in hospitalization?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[12 August 2026]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: