

Prior Authorization Request Form for
Nasal Allergy Drugs



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 HEALTHCARE

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**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.

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. Which medication is requested?	<input type="checkbox"/> Beconase AQ (beclomethasone) – Proceed to question 2 <input type="checkbox"/> Nasonex (mometasone) – Proceed to question 2 <input type="checkbox"/> Rhinocort Aqua (budesonide) – Proceed to question 3 <input type="checkbox"/> Dymista (fluticasone/azelastine) – Proceed to question 6 <input type="checkbox"/> All others – Proceed to question 4	
2. <i>(Beconase AQ / beclomethasone or Nasonex / mometasone request)</i> Does the patient have nasal polyps and cannot be treated with azelastine 137 mcg nasal spray (Astelin), flunisolide nasal spray, fluticasone propionate nasal spray (Flonase), or ipratropium nasal spray (Atrovent nasal spray)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No SKIP to question 4
3. <i>(Rhinocort Aqua / budesonide request)</i> Is the patient a female who is pregnant?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 4
4. Has the patient tried azelastine 137 mcg nasal spray (Astelin), flunisolide nasal spray, fluticasone propionate nasal spray (Flonase), or ipratropium nasal spray (Atrovent nasal spray) and experienced an inadequate response or an intolerable adverse effect (for example, persistent nose bleed, significant nasal irritation, or sore throat)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 5

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5. Does the patient have a contraindication to ALL of the following: azelastine 137 mcg nasal spray (Astelin), flunisolide nasal spray, fluticasone propionate nasal spray (Flonase), and ipratropium nasal spray (Atrovent nasal spray)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient experienced an inadequate response or intolerable adverse effects (for example, persistent nose bleed, significant nasal irritation, or sore throat) with at least TWO of the following: azelastine 137 mcg nasal spray (Astelin), flunisolide nasal spray, fluticasone propionate nasal spray (Flonase), or ipratropium nasal spray (Atrovent nasal spray)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 7
7. Does the patient have a contraindication to at least TWO of the following: azelastine 137 mcg nasal spray (Astelin), flunisolide nasal spray, fluticasone propionate nasal spray (Flonase), and ipratropium nasal spray (Atrovent nasal spray)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[14 November 2017]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: