Prior Authorization Request Form for
Nasal Allergy Drugs

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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.

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?	☐ **Beconase AQ** (beclomethasone) – **Proceed to question 2** ☐ **Nasonex** (mometasone) – **Proceed to question 2** ☐ **Rhinocort Aqua** (budesonide) – **Proceed to question 3** ☐ **Dymista** (fluticasone/azelastine) – **Proceed to question 6** ☐ **All others – Proceed to question 4**	
2. *(Beconase AQ / beclomethasone or Nasonex / mometasone request)* **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)**?**	☐ Yes **Sign and date below**	☐ No **SKIP** to question **4**
3. *(Rhinocort Aqua / budesonide request)* **Is the patient a female who is pregnant?**	☐ Yes **Sign and date below**	☐ 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)**?**	☐ Yes **Sign and date below**	☐ 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)**?**	☐ Yes **Sign and date below**	☐ 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)?	☐ Yes **Sign and date below**	☐ 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)?	☐ 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

[14 Novmber 2017]

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