SENTARA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Nasal Corticosteroids (select one below)

❑ **azelastine HCl-fluticasone propionate** (Dymista®)	❑ **Beconase AQ®** (beclomethasone)	❑ **flunisolide nasal spray**
❑ **mometasone** (Nasonex®)	❑ **Omnaris®** (ciclesonide)	❑ **Qnasl®** (beclomethasone)
❑ **Xhance®**(fluticasone propionate)	❑ **Zetonna™** (ciclesonide)	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: Check below all that apply. **All criteria must be met for approval**. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

For all non-preferred nasal corticosteroid requests EXCEPT Xhance®:

- ❑ Member must have documentation of trial and failure of **TWO (2)** of the following **(check each that has been tried, trials will be verified through paid pharmacy claims or chart notes):**
  - ❑ Prescription fluticasone propionate nasal spray (generic Flonase®)

(Continued on next page)

- ❑ OTC budesonide nasal spray (generic Rhinocort Allergy®)
- ❑ OTC triamcinolone acetonide nasal spray (generic Nasacort®)

OR

- ❑ **If requesting mometasone (Nasonex®),** member has a diagnosis of Chronic Rhinosinusitis with Nasal Polpys (CRSwNP) confirmed by **ONE (1)** of the following **(submit documentation to confirm diagnosis)**:
  - ❑ Anterior rhinoscopy
  - ❑ Nasal endoscopy
  - ❑ Computed tomography

For Xhance® Requests:

- ❑ Member must be 18 years of age or older
- ❑ Member has a diagnosis of Chronic Rhinosinusitis with Nasal Polpys (CRSwNP) confirmed by **ONE (1)** of the following **(submit documentation to confirm diagnosis)**:
  - ❑ Anterior rhinoscopy
  - ❑ Nasal endoscopy
  - ❑ Computed tomography
- ❑ Prescribed by or in consultation with an allergist, ENT specialist or pulmonologist
- ❑ Member must have documentation of a 90-day trial and failure, contraindication or intolerance to **TWO (2)** intranasal corticosteroids **(check each that has been tried, trials will be verified through paid pharmacy claims or chart notes):**
  - ❑ Mometasone nasal spray (generic Nasonex®) ***requires prior authorization***
  - ❑ Prescription fluticasone propionate nasal spray (generic Flonase®)
  - ❑ OTC budesonide nasal spray (generic Rhinocort Allergy®)
  - ❑ OTC triamcinolone acetonide nasal spray (generic Nasacort®)
  - ❑ Other: _____

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****