

**Nasal Corticosteroids Prior Authorization Request Form**  
 DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

<b>Member Information</b> (required)			<b>Provider Information</b> (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

<b>Medication Information</b> (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

<b>Clinical Information</b> (required)
<b>Select the requested drug below:</b> <input type="checkbox"/> Flonase <input type="checkbox"/> Omnaris
<b>What is the patient's diagnosis for the medication being requested?</b> _____ ICD-10 Code(s): _____
<b>Medication history:</b> Has the patient tried and failed fluticasone nasal spray? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried and failed budesonide nasal spray? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</b> <b>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</b>
<b>Prescriber Signature:</b> _____ <b>Date:</b> _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.