

XHANCE

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient diagnosis:

Chronic rhinosinusitis with nasal polyps (CRSwNP)

Chronic rhinosinusitis without nasal polyps (CRSsNP)

Other (ICD code and description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

- Is the patient currently treated with the requested agent? Yes No
If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.**..... Yes No
- Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
If yes, please specify FDA labeled contraindications: _____

- Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____

- Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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Please submit chart notes to support the answers to the following questions:

5. Has the patient tried and had an inadequate response to ONE generic OR OTC intranasal corticosteroid? Yes No
6. Was ONE generic OR OTC intranasal corticosteroid discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
7. Does the patient intolerance or hypersensitivity to generic or OTC intranasal corticosteroids that is not expected to occur with the requested agent?..... Yes No
8. Does the patient an FDA labeled contraindication to ALL generic and OTC intranasal corticosteroids that is not expected to occur with the requested agent?..... Yes No
9. Is ONE generic OR OTC intranasal corticosteroid expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
10. Is ONE generic OR OTC intranasal corticosteroid not in the best interest of the patient based on medical necessity? Yes No
11. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE generic OR OTC intranasal corticosteroid and that drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For renewal requests:

12. Has the patient had clinical benefit with the requested agent?..... Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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