EXPRESS SCRIPTS®

Prior Authorization Form
Nasal Steroids Step Therapy

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Beconase AQ 0.042% Nasal Spray
- ☐ Flonase 50mcg/actuation Nasal Spray
- ☐ Nasacort AQ 55mcg/actuation Nasal Spray
- ☐ Dymista 137 mcg-50mcg/actuation Nasal Spray
- ☐ Zetonna 37 mcg/actuation Nasal Spray
- ☐ Nasonex 50mcg/actuation Nasal Spray
- ☐ Omnaris 50mcg/actuation Nasal Spray
- ☐ Qnasl 80mcg/actuation Nasal Spray
- ☐ Rhinocort AQ 32mcg/actuation Nasal Spray
- ☐ Veramyst 27.5mcg/actuation Nasal Spray

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:			
1. Is the patient currently taking the requested medication?	☐ Yes	☐ No	☐ N/A
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: ☐ Requested medication covered under previous insurance plan ☐ Started medication in hospital ☐ Other: _____	☐ Yes	☐ No	☐ N/A
3. For Rhinocort Aqua requests only, is the patient a pregnant female?	☐ Yes	☐ No	☐ N/A

4. Has the patient tried any of the following medications for their current condition? If yes, please indicate: ☐ Generic Fluticasone Propionate Nasal Spray ☐ Generic Flunisolide Nasal Spray ☐ Generic Triamcinolone Acetonide Nasal Spray ☐ Nasacort AQ ☐ Nasonex ☐ Qnasl ☐ Veramyst ☐ Other: _____ _____	☐ Yes	☐ No

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

_____

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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