

Nasal Steroids (FA-EXC) – Prior Authorization Request

Send completed form to: CVS/caremark Fax: 888-487-9257

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-487-9257**. Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nasal Steroids (FA-EXC).

Patient Name:	Date:
Patient's ID:	Patient's Group #:
Patient's Date of Birth:	Patient's Phone:
Physician's Name:	
Physician's Address:	
Specialty:	NPI #:
Physician Office Telephone:	Physician Office Fax:

1. What drug is being prescribed?
- | | |
|--|---|
| <input type="checkbox"/> Beconase AQ (beclomethasone dipropionate) | <input type="checkbox"/> Rhinocort AQ (budesonide) |
| <input type="checkbox"/> Omnaris (ciclesonide) | <input type="checkbox"/> Veramyst (fluticasone furoate) |
| <input type="checkbox"/> Qnasl (beclomethasone dipropionate) | <input type="checkbox"/> Zetonna (ciclesonide) |
| <input type="checkbox"/> Other _____ | |
- Quantity: _____ Frequency: _____ Strength: _____
- Route of administration: _____ Expected Length of Therapy: _____

2. What is the patient's diagnosis? _____
3. What is the ICD code? _____
4. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Yes No
5. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? Yes No (If yes, no further questions – please document drug name, trial year and reason for failure.) _____
- _____
- _____

Requirement: 3 in a class with 3 or more alternatives: flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX

6. Does the patient have a documented clinical reason such as expected adverse reaction or contraindication that prevents them from trying the formulary alternatives listed below? Yes No (If yes, please document the reason(s) the patient cannot try the formulary alternatives.) _____
- _____
- _____

Formulary alternatives: flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature **Date: (mm/dd/yy)**

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