



Date _____

Client _____

PRIOR AUTH CRITERIA- INTRANASAL STEROIDS

M.D. Last Name: _____ M.D. First Name: _____

Physician Phone: _____ Physician Fax: _____

Patient _____ ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please circle which agent is being requested:

STEP B*

Nasacort AQ Nasonex Rhinocort Aqua Veramyst

STEP C**

Beconase AQ Branded Flonase Branded Nasarel Omnaris

***Please note that if member is beginning therapy with an Intranasal Steroid, the member's benefit will only cover generic flunisolide/fluticasone, unless the member has already tried and failed generic flunisolide and generic fluticasone**

****Please Note that Step C drugs will not be approved unless all Step B drugs have been tried and failed**

2. Please circle the patient's diagnosis:

Allergic Rhinitis Nasal Polyps Rhinitis Other _____

If "Other" diagnosis is used, please attach a study with efficacy data supporting this request

3. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of generic flunisolide? Yes No

4. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of generic fluticasone? Yes No

5. Please explain the reason for failure or non-trial, and attach notes from the patient's chart as documentation.

6. Please indicate the patient's age _____

7. Is the patient pregnant? Yes No

8. Does the patient have a hypersensitivity to any of the components of the requested medication? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906