

## INTRANASAL RHINITIS AGENTS PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Intranasal Rhinitis Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Intranasal Rhinitis Agents** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name:	
<input type="checkbox"/> Renewal request	# of pages in request: _____		
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

### CLINICAL INFORMATION

<b>Non-preferred medication requested:</b>	<input type="checkbox"/> <i>Astepro 0.15%</i>	<input type="checkbox"/> <b>Beconase AQ</b>	<input type="checkbox"/> <b>Flonase OTC</b>	<input type="checkbox"/> <b>Omnaris</b>	<input type="checkbox"/> <b>triamcinolone</b>
	<input type="checkbox"/> <i>Atrovent nasal*</i>	<input type="checkbox"/> <b>budesonide</b>	<input type="checkbox"/> <b>flunisolide</b>	<input type="checkbox"/> <b>Qnasl</b>	<input type="checkbox"/> <b>Veramyst</b>
	<input type="checkbox"/> <i>azelastine 0.15%</i>	<input type="checkbox"/> <b>Dymista</b>	<input type="checkbox"/> <i>olopatadine</i>	<input type="checkbox"/> <b>Rhinocort Aqua</b>	<input type="checkbox"/> <b>Zetonna</b>
<i>(Antihistamine nasal sprays are in italics; steroid and steroid/antihistamine combination nasal sprays are in bold; anticholinergic nasal spray is indicated with *)</i>					
Strength:	Directions:	Quantity:	Refills:		
Diagnosis:			Diagnosis code (required):		
<b><u>SECTION A: ANTIHISTAMINE NASAL SPRAYS</u></b>					
1. Has the Recipient tried and failed, or have a contraindication or intolerance to, the preferred antihistamine Intranasal Rhinitis Agents? <input type="checkbox"/> azelastine 0.1% <input type="checkbox"/> Patanase				<input type="checkbox"/> Yes <i>Submit medical record documentation of Recipient's medication regimen and response to treatment</i> <input type="checkbox"/> No	
<b><u>SECTION B: STEROID AND STEROID/ANTIHISTAMINE COMBINATION NASAL SPRAYS</u></b>					
1. Has the Recipient tried and failed, or have a contraindication or intolerance to, the preferred steroid Intranasal Rhinitis Agents? <input type="checkbox"/> fluticasone <input type="checkbox"/> Nasonex				<input type="checkbox"/> Yes <i>Submit medical record documentation of Recipient's medication regimen and response to treatment</i> <input type="checkbox"/> No	
<b><u>SECTION C: ANTICHOLINERGIC NASAL SPRAYS</u></b>					
1. Has the Recipient tried and failed, or have a contraindication or intolerance to, the preferred anticholinergic Intranasal Rhinitis Agent? <input type="checkbox"/> ipratropium 0.03% <input type="checkbox"/> ipratropium 0.06%				<input type="checkbox"/> Yes <i>Submit medical record documentation of Recipient's medication regimen and response to treatment</i> <input type="checkbox"/> No	

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature:	Date:
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