

US Family Health Plan
 Prior Authorization Request Form for
 fluticasone propionate 93 mcg nasal spray (**Xhance**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____
 Address: _____ Address: _____
 Sponsor ID # _____ Phone #: _____
 Date of Birth: _____ Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Does the patient have nasal polyps?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Has the patient tried and failed at least two of the following: azelastine 137 mcg nasal spray (generic Astelin), flunisolide nasal spray, fluticasone propionate 50 mcg nasal spray (generic Flonase), or ipratropium nasal spray (Atrovent nasal spray)?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Has the patient experienced therapeutic failure with a trial of mometasone (Nasonex) OR beclomethasone (Beconase)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

 Prescriber Signature _____
 Date