

US Family Health Plan
Prior Authorization Request Form for
olopatadine hydrochloride/mometasone furoate monohydrate (Ryaltris)

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 855-273-5735

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):

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

Step 2 Please complete the clinical assessment:

2	1. Is the patient greater than or equal to 12 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
	2. Has the patient tried azelastine 137 mcg nasal spray (Astelin), flunisolide nasal spray, fluticasone propionate nasal spray (Flonase), or ipratropium nasal spray (Atrovent nasal spray) and experienced an inadequate response or an intolerable adverse effect (for example, persistent nose bleed, significant nasal irritation, or sore throat)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
	3. Does the patient have a contraindication to ALL of the following: azelastine 137 mcg nasal spray (Astelin), flunisolide nasal spray, fluticasone propionate nasal spray (Flonase), and ipratropium nasal spray (Atrovent nasal spray)?	<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:

3	Prescriber Signature	Date
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