# USFHP 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 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**

**https://www.usfamilyhealth.org/for-providers/pharmacy-information/**

**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 chronic rhinosinusitis with nasal polyposis confirmed by imaging or direct visualization?**<br>Note: Non-FDA-approved uses are NOT approved, including allergic rhinitis. | ☐ Yes<br>Proceed to question 2 | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question 3 | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Is the prescription written by or in consultation with an allergist, immunologist, pulmonologist, or otolaryngologist?** | ☐ Yes<br>Proceed to question 4 | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Are the symptoms of chronic rhinosinusitis with nasal polyposis inadequately controlled despite all of the following maximized treatments?**<br>• **Nasal saline irrigation**<br>• **Adequate duration of at least TWO of the following**<br>▪ fluticasone propionate (generic Flonase)<br>▪ flunisolide (generic Nasarel)<br>▪ beclomethasone (Beconase AQ, QNASL)<br>▪ budesonide (Rhinocort Aqua, generic)<br>▪ mometasone (Nasonex, generics)<br>▪ nasal corticosteroid irrigation/rinse | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

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

_____ _____

Prescriber Signature Date

[20 April 2022]