pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

INTRANASAL RHINITIS AGENTS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Intranasal Rhinitis Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Astepro 0.15%	☐flunisolide	☐Omnaris	☐triamcinolone OTC
☐azelastine 0.15%	☐fluticasone OTC	☐Patanase	☐Xhance
☐Beconase AQ	☐mometasone	☐Qnasl 80 mcg	☐Zetonna
☐Flonase Allergy Relief	☐Nasonex	☐Qnasl Children's 40 mcg	☐________________
☐Flonase Sensimist	☐olopatadine	☐Sinuva implant	

Strength:	Directions:	Quantity:	Refills:

Diagnosis:	Diagnosis code *(required)*:
1. Did the beneficiary try and fail the preferred Intranasal Rhinitis Agents? ☐azelastine 0.1% ☐cromolyn sodium ☐fluticasone propionate Rx ☐budesonide ☐Dymista ☐ipratropium	☐Yes ☐No *Submit medical record documentation of beneficiary's medication regimen and response to treatment.*
2. Does the beneficiary have a contraindication or intolerance to the preferred agents listed in the previous question?	☐Yes ☐No *Submit medical record documentation of contraindications/intolerances.*

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

Prescriber Signature:	**Date**:

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