PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 8/9/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the treatment of chronic rhinosinusitis with or without nasal polyps in an adult?	**Y** ☐	**N** ☐
2.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
3.	Has the patient achieved or maintained a positive clinical response to the requested drug (i.e., improvement in nasal congestion, mucopurulent drainage, facial pain/pressure/fullness, sense of smell, improvement in polyp grade)?	**Y** ☐	**N** ☐
4.	Has the patient experienced an inadequate treatment response to an alternative intranasal corticosteroid therapy?	**Y** ☐	**N** ☐
5.	Has the patient experienced an intolerance to an alternative intranasal corticosteroid therapy?	**Y** ☐	**N** ☐
6.	Is the patient a candidate for a trial with an alternative intranasal corticosteroid therapy?	**Y** ☐	**N** ☐
7.	Does the patient require MORE than the plan allowance of 2 packages (16 mL each) of Xhance (fluticasone propionate) nasal spray per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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