REALRx

PRIOR AUTHORIZATION REQUEST FORM
XHANCE®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ fluticasone propionate nasal spray ☐ mometasone nasal spray
Non-preferred: ☐ Xhance® (fluticasone propionate)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) or chronic rhinosinusitis without nasal polyposis?	☐	☐	**Please provide documentation**
3. Is the request being made by or in consultation with an allergist, ENT specialist, or pulmonologist?	☐	☐	
4. Is the member at 18 years of age or older?	☐	☐	
5. Does documentation show a 3-month trial and failure of or contraindication/intolerance to BOTH of the following intranasal steroids? • fluticasone propionate 50 mcg/actuation nasal spray • mometasone furoate 50 mcg/actuation nasal spray	☐	☐	**Please provide documentation**
6. For chronic rhinosinusitis **with nasal polyposis (CRSwNP):** Does documentation show diagnosis confirmed by one of the following: • Anterior rhinoscopy • Nasal endoscopy • Computed tomography (CT)	☐	☐	**Please provide documentation**

7. For chronic rhinosinusitis **without** nasal polyposis: Does documentation show the member has at least two of four cardinal symptoms: nasal obstruction, anterior or posterior nasal discharge, reduction or loss of smell, and facial pain/pressure/fullness for at least 12 weeks duration?	☐	☐	**Please provide documentation**
8. For chronic rhinosinusitis **without** nasal polyposis: Does documentation include objective evidence of mucosal inflammation, either by direct visualization or on an imaging study (sinus computed tomography [CT] scan)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM- 086
Origination Date: 10/28/2019
Reviewed/Revised Date: 05/22/2024
Next Review Date: 05/22/2025
Current Effective Date: 06/01/2024