HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
XHANCE®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department 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. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)?	☐	☐	**Please provide documentation**
2. Is the request being made by or in consultation with an allergist, ENT specialist, or pulmonologist?	☐	☐	
3. Is the member at 18 years of age or older?	☐	☐	
4. 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**
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-HU-086
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025