

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)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the request being made by or in consultation with an allergist, ENT specialist, or pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member at 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does documentation show a 3 month trial and failure of or contraindication/intolerance to BOTH of the following intranasal steroids? <ul style="list-style-type: none"> fluticasone propionate 50 mcg/actuation nasal spray mometasone furoate 50 mcg/actuation nasal spray 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	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

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