Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Intranasal Corticosteroids Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist**.

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

- ☐ Beconase AQ (beclomethasone nasal spray) > 1 inhaler/month
- ☐ flunisolide nasal spray
- ☐ fluticasone propionate 50 mcg nasal spray > 1 inhaler/month
- ☐ mometasone nasal spray
- ☐ Omnaris (ciclesonide nasal spray, 50 mcg)
- ☐ Qnasl (beclomethasone nasal aerosol)
- ☐ Sinuva (mometasone sinus implant)
- ☐ Xhance (fluticasone propionate 93 mcg nasal spray)
- ☐ Zetonna (ciclesonide nasal aerosol, 37 mcg) > 1 inhaler/month

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

☐ Allergic rhinitis ☐ Nasal polyps ☐ Nasal polyps with a history of ethmoid sinus surgery

☐ Non-allergic rhinitis ☐ Other (please indicate) _____

Section I. Please complete for requests for flunisolide nasal spray, mometasone nasal spray, Omnaris, and Qnasl.

For members ≥ 6 years of age, please complete questions 1 through 3. For members 4 to 5 years of age, please complete questions 1 and 3. For members < 4 years of age, please complete question 3.

1. Has the member had a trial with fluticasone propionate 50 mcg nasal spray?
   ☐ Yes. Please list the dates/duration of trials, and outcomes.* Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
   _____
   ☐ No. Please describe clinical rationale for not using fluticasone propionate 50 mcg nasal spray.
   _____
2. Has the member had a trial with budesonide over-the-counter (OTC) nasal spray?
   ☐ Yes. Please list the dates/duration of trials, and outcomes.* Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

_____

☐ No. Please describe clinical rationale for not using budesonide OTC nasal spray.

_____

3. Has the member had a trial with triamcinolone OTC nasal spray?
   ☐ Yes. Please list the dates/duration of trials, and outcomes.* Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

   _____

   ☐ No. Please describe clinical rationale for not using triamcinolone OTC nasal spray.

   _____

Section II. Please complete for any agent at a quantity > one inhaler per month. Please complete Section I above as appropriate.

1. Has the member had a trial with two intranasal or second-generation oral antihistamines?
   ☐ Yes. Please list the dates/duration of trials and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

   _____

   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

   _____

   ☐ No. Please describe clinical rationale for not using intranasal or second-generation oral antihistamines.

   _____

2. For requests for any agent at a quantity > one inhaler per month, please attach medical records documenting an inadequate response to the manufacturer's recommended dosing.

Section III. Please complete for requests for Sinuva.

1. Please indicate prescriber specialty below.
   ☐ Otolaryngologist ☐ Other _____
2. Has the member had a trial with two intranasal corticosteroids?
   ☐ Yes. Please list the dates/duration of trials and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

   _____

   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

   _____

   ☐ No. Please describe clinical rationale for not using intranasal corticosteroids.

   _____

3. Has the member had a trial with an oral corticosteroid?
   ☐ Yes. Please list the dates/duration of trials and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

over

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

_____

☐ No. Please describe clinical rationale for not using an oral corticosteroid.

_____

**Please attach a letter documenting additional trials as necessary.*

Section IV. Please complete for requests for Xhance.

Please describe medical necessity for use of the requested agent instead of all other intranasal corticosteroids.

_____

_____

Section V. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____