



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

## 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](http://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

- |                                                                                         |                                                                                           |
|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Beconase AQ (beclomethasone nasal spray) > 1<br>inhaler/month  | <input type="checkbox"/> Omnaris (ciclesonide nasal spray, 50 mcg)                        |
| <input type="checkbox"/> flunisolide nasal spray                                        | <input type="checkbox"/> Qnasl (beclomethasone nasal aerosol)                             |
| <input type="checkbox"/> fluticasone propionate 50 mcg nasal spray > 1<br>inhaler/month | <input type="checkbox"/> Sinuva (mometasone sinus implant)                                |
| <input type="checkbox"/> mometasone nasal spray                                         | <input type="checkbox"/> Xhance (fluticasone propionate 93 mcg nasal spray)               |
|                                                                                         | <input type="checkbox"/> Zetonna (ciclesonide nasal aerosol, 37 mcg) > 1<br>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.

- 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.  
 \_\_\_\_\_
- 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 Nasacort Allergy 24HR 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 Nasacort Allergy 24HR OTC nasal spray.

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**Section II. Please complete for any agent at a quantity > 1 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 > 1 inhaler per month, please attach medical records documenting an inadequate response to the manufacturer's recommended dosing.

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**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

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.*

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**Section IV. Please complete for requests for Xhance.**

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

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**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.

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**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*

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**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 \_\_\_\_\_