OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
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Beconase AQ®, Dymista®, Flonase®, Nasacort®, Omnaris®, Qnasl®, Rhinocort® & Zetonna®
Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	ZIP:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	ZIP:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
	Directions for Use:

Clinical Information (required)

1. What is the patient's diagnosis for the medication being requested? _____ ICD-10 Code(s): _____	
2. Is the drug being prescribed within the manufacturer's published dosing guidelines or does the dose fall within dosing guidelines found in accepted compendia or current literature (e.g., package insert, AHFS, Micromedex, current accepted guidelines, etc.)?	❑ Yes ❑ No
3. Has the patient had a trial and failure or intolerance to a majority (two or more in a class with at least two alternatives or one in a class with only one alternative) of the preferred formulary/preferred drug list alternatives for the given diagnosis (e.g., budesonide nasal spray, flunisolide spray, fluticasone spray, triamcinolone spray, mometasone spray)? If yes, please document the medication(s) tried, dates of trial(s) and reason for treatment failure(s): _____	❑ Yes ❑ No
4. Does the patient have a documented contraindication to the listed formulary alternatives (e.g., budesonide nasal spray, flunisolide spray, fluticasone spray, triamcinolone spray, mometasone spray)? If yes, please document the medication name(s) and contraindication:_____ _____	❑ Yes ❑ No
5. Has the patient had a documented adverse reaction to OR would be reasonably expected to have an adverse reaction to a majority (two or more in a class with at least two alternatives or one in a class with only one alternative) of the listed formulary agents used for the requested indication (e.g., budesonide nasal spray, flunisolide spray, fluticasone spray, triamcinolone spray, mometasone spray)? If yes, please document the medication name(s) and adverse reaction(s):_____ _____	❑ Yes ❑ No
6. Does the patient have a clinical condition for which there is no listed formulary agent to treat the condition based on published guidelines or clinical literature? If yes, please document the clinical condition:_____	❑ Yes ❑ No

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Prior Authorization Request Form (Page 2 of 2)

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern