10/05/2015

Prior Authorization Form

GEHA

Dymista (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Dymista (FA-PA).

Drug Name (select from list of drugs shown)

Dymista (fluticasone- azelastine)

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Y	N	
2. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? (IF YES, PLEASE DOCUMENT DRUG NAME, TRIAL YEAR AND REASON FOR FAILURE) REQUIREMENT: 3 in a class with 3 alternatives: flunisolide spray, fluticasone spray, triamcinolone spray or NASONEX WITH azelastine spray or olopatadine spray [If yes, then no further questions.]	Y	N	

3. Does the patient have a documented clinical reason such as expected adverse reaction or contraindication that prevents them from trying the formulary alternatives listed below? (IF YES, PLEASE DOCUMENT THE REASON(S) THE PATIENT CAN NOT TRY THE FORMULARY ALTERNATIVES) Formulary alternatives are: flunisolide spray, fluticasone spray, triamcinolone spray or NASONEX WITH azelastine spray or olopatadine spray	Y	N	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date