



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Intranasal Rhinitis Agents

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	PA PROMISe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for triamcinolone nasal spray?

Yes

No

Q2. Is the patient 4 years of age or older?

[Note: Prior Authorization is not required for triamcinolone nasal spray for patients less than 4 years of age.]

Yes

No

Q3. Is this a request for an intranasal rhinitis drug (i.e., intranasal antihistamine or intranasal steroid) when there is a record of a recent paid claim for another intranasal rhinitis drug with the same mechanism of action (i.e., potential therapeutic duplication)?

Yes

No

Q4. Is the patient being titrated to or tapered from another intranasal rhinitis drug containing a drug with the same mechanism of action?

Yes

No

Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?



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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is this a request for a preferred intranasal rhinitis drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of a preferred intranasal rhinitis drug with the same mechanism of action?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Additional Information:	

Prescriber Signature

Date

v2026-06