ATRIO
HEALTH PLANS

Sinuva
Sinuva (mometasone furoate) J7402
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request**– (72 Hours)	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)

Date Requested _____

Requestor _____ Clinic name: _____ Phone   / Fax

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____   ☐MD ☐FNP ☐DO ☐NP ☐PA   *Phone:_____

*Address:_____   *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____   Phone:_____

*Address:_____   Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered**   ☐ **Provider-administered**   ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____   **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Nasal Polyps – Recurrent**
    ☐ Patient is 18 years or older
    ☐ Confirmed diagnosis of nasal polyps via nasal endoscopy
    ☐ Patient has history of prior sinus surgery for nasal polyps
    ☐ Patient has recurrent polyposis despite maximal medical therapy (including intranasal corticosteroids)
    ☐ Patient is not a candidate for or declines repeat sinus surgery
    ☐ Prescribed by or in consultation with otolaryngologist

    If not, please provide **clinical rationale** for formulary exception: _____
    _____

☐ Continuation Requests: (Clinical documentation required for all requests)

    ☐ Patient had an **adequate response** or **significant improvement** while on this medication.

        ☐ Medical record documentation of positive response is included

    If not, please provide clinical rationale for continuing this medication: _____
_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____**Date:_____ /_____ /_____**

Prior Authorization Group – Sinuva Prior Authorization

Drug Name(s):
SINUVA   **MOMETASONE FUROATE**

Criteria for approval of Non-Formulary/Preferred Drug:
1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan, in accordance with the Label.
- Continuation Requests: Provider must verify continued clinical benefit in confirmatory trial(s).

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Approval will be for 6 months

FDA Indications:
Sinuva
- Allergic rhinitis, Seasonal and perennial
- Asthma, Maintenance therapy; Prophylaxis
- Inflammatory hyperkeratotic dermatosis
- Nasal congestion - Seasonal allergic rhinitis
- Polyp of nasal cavity and/or nasal sinus
- Polyp of nasal cavity and/or nasal sinus, In patients who have had ethmoid sinus surgery - Rhinosinusitis, chronic
- Seasonal allergic rhinitis; Prophylaxis

Off-Label Uses:
Rhinitis; Adjunct - Sinusitis; Adjunct

Age Restrictions:
- Avoid topical use in children under 2 years old

Other Clinical Consideration:
N/A

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/PFDefaultActionId/evidencexpert.DoIntegratedSearch?SearchTerm=sinuva&SearchFilter=filterNone#