BlueCross BlueShield
Federal Employee Program

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

SINUVA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER COMPLETES

Date: ____ / ____ / ____

Patient Name: _____/ _____ / _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F ____

R _____
Cardholder Identification Number

Sinuva (mometasone furoate)
NOTE: Form must be completed in its entirety for processing

1. What is the patient's diagnosis?

- ☐ **Nasal polyps**
- ☐ **Recurrent nasal polyp disease**
- ☐ **Post sinus surgery**
- ☐ **Other diagnosis (please specify):**

_____

2. Has the patient received Sinuva previously? ☐ **Yes*** ☐ **No**
***If YES, which nostril was previously treated?** ☐ **Left nostril** ☐ **Right nostril** ☐ **Both nostrils**

3. Which nostril is going to be treated? ☐ **Left nostril** ☐ **Right nostril** ☐ **Both nostrils**

4. Does the patient have a history of ethmoid sinus surgery? ☐ **Yes** ☐ **No**

5. Has the patient had an inadequate response to a 3-month trial of TWO nasal corticosteroid sprays, such as mometasone, fluticasone, budesonide, or triamcinolone? ☐ **Yes** ☐ **No**

6. Does the patient had a contraindication to oral corticosteroids, such as prednisone, methylprednisolone, or dexamethasone? ☐ **Yes** ☐ **No***
***If NO, has the patient had an inadequate response or an intolerance to a 14-day trial of an oral corticosteroid?** ☐ **Yes** ☐ **No**

7. Is the administering physician an Otolaryngologist (ENT)? ☐ **Yes** ☐ **No**

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ / _____ / _____
Prescriber's NPI Physician Signature Date