



Preferred Pharmacy Network Form

Please fill out the Patient Information, Patient Insurance, and Preferred Pharmacy sections and take this form to your doctor.

Patient Information

Patient Name _____ DOB ____/____/____ Sex M F
 Street Address _____ City _____ State _____ ZIP _____
 Mobile Phone (____) _____ - _____ Home Phone (____) _____ - _____ Email _____

Patient Insurance Information

Prescription Plan Name _____ Group # _____
 Policy # _____ Rx BIN # _____ Rx PCN # _____
 Insurance Phone (____) _____ - _____ Policy # _____ Policyholder Name _____ DOB ____/____/____

Preferred Pharmacy Information (Please use the pharmacy locator at xhance.com/pharmacylocator.)

Pharmacy Name _____ Fax (____) _____ - _____ Phone (____) _____ - _____

The following section is to be filled out by your doctor's office

Prescriber Information

Prescriber Name _____ Title _____ NPI # _____ Tax ID # _____
 Facility Name/Address _____ City _____ State _____ ZIP _____
 Office Contact Name _____ Office Contact Email _____
 Phone (____) _____ - _____ Fax (____) _____ - _____ Supervising Physician _____

Clinical Information for Insurance Prior Authorizations (Please include a copy of patient's clinical notes, if available.)

Diagnosis

J33.0 Polyp of nasal cavity J33.1 Polypoid sinus degeneration J33.8 Other polyp of sinus J33.9 Nasal polyp, unspecified
 Other Dx code(s) _____

Most Recent Steroid Treatment

Flonase Dymista QNASL Nasonex Nasacort Rhinocort Other _____
 Approximate start and end dates of most recent treatment _____
 Surgical history _____
 Drug allergies _____

Prescription

Rx: XHANCE (fluticasone propionate) nasal spray 93 mcg, NDC: 71143-375-01

1 spray per nostril twice daily: Dispense 1 unit REFILLS: 1 2 3 4 5 6 12
 2 sprays per nostril twice daily: Dispense 2 units

Prescriber Authorization (Required)

I authorize the designated pharmacy to act as an agent to initiate and execute the insurance prior authorization process, if necessary, for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice.

Prescriber's Signature _____ / _____ Date ____/____/____
 (Substitutions Permitted) (Dispense as Written)

PLEASE COMPLETE AND SIGN THIS FORM. FAX COMPLETED FORM TO PREFERRED PHARMACY ABOVE.

This fax is intended to be delivered to the named addressee. It contains material that is confidential, proprietary, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify immediately if you have received this document in error and then destroy this document immediately.

Please see Indication, Important Safety Information and full Prescribing Information for XHANCE at XhanceHCP.com.

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