Please complete ALL information below and fax your request to 1-888-671-5285

Odactra™ Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ House dust mite (HDM)-induced allergic rhinitis with or without conjunctivitis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Was the patient's diagnosis of house dust mite (HDM)-induced allergic rhinitis confirmed by in vitro testing for IgE antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites OR skin testing to licensed house dust mite allergen extracts? ❑ **Yes** ❑ **No**

Was Odactra prescribed by a physician experienced in immunotherapy or by a prescriber who conducted the allergy testing? ❑ **Yes** ❑ **No**

Does the patient have severe, unstable or uncontrolled asthma? ❑ **Yes** ❑ **No**

Does the patient have a history of eosinophilic esophagitis? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to or inability to tolerate intranasal corticosteroid AND an antihistamine? ❑ **Yes** ❑ **No**

Reauthorization:

For reauthorization requests, ALSO answer the following:

Has the patient experienced improvement in the symptoms of their allergic rhinitis or a decrease in the number of medications needed to control allergy symptoms? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.