



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: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic) <input type="checkbox"/> Check if request is for continuation of therapy	Strength:	Dosage Form:
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.

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