FUTURE SCRIPTS

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

Grastek®, Odactra™, Oralair®, Ragwitek® Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Grass pollen-induced allergic rhinitis, with or without conjunctivitis
- ❑ House dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis
- ❑ Short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Skin-In vitro testing:

For Grastek requests, answer the following:

Does the patient have a positive skin test or in vitro test to Timothy Grass or cross-reactive grass pollens? ❑ **Yes** ❑ **No**

For Odactra requests, answer the following:

Does the patient have a positive skin test or in vitro test to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites? ❑ **Yes** ❑ **No**

For Oralair requests, answer the following:

Does the patient have a positive skin test or in vitro test to any of the five grass species including sweet vernal, orchard, perennial rye, Timothy or Kentucky blue grass mixed pollens? ❑ **Yes** ❑ **No**

For Ragwitek requests, answer the following:

Does the patient have a positive skin test or in vitro test to short ragweed pollen? ❑ **Yes** ❑ **No**

Patient history:

Was the requested medication prescribed by the prescriber that conducted the above 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 an intranasal corticosteroid? ❑ **Yes** ❑ **No**

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

Reauthorization:

If this is a reauthorization request, answer the following:

Is the requested medication annually reviewed and prescribed by an appropriate provider experienced in immunotherapy? ❑ **Yes** ❑ **No**

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.