



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

# Grastek<sup>®</sup>, Odactra<sup>™</sup>, Oralair<sup>®</sup>, Ragwitek<sup>®</sup> Prior Authorization Request Form

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| 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: |
| <input type="checkbox"/> Check if generic substitution is acceptable     | Directions for Use: |              |
| <input type="checkbox"/> Check if request is for continuation of therapy |                     |              |

| Clinical Information (required)  |  |
|--|--|
| <b>Select the diagnosis below:</b>   |  |
| <input type="checkbox"/> Grass pollen-induced allergic rhinitis, with or without conjunctivitis          |  |
| <input type="checkbox"/> House dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis |  |
| <input type="checkbox"/> Short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis  |  |
| <input type="checkbox"/> 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.

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