OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay the authorization process.***

Drug Requested: ***Oral Anti-Allergens (Non-Preferred)*** ***(MEDICAID)***
(Non-Preferred Medication (requires PA))

❑ **Grastek® SL**	❑ **Oralair® SL**	❑ **Ragwitek® SL**

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Name/Form: _____ **Strength**: _____

Dosing Frequency: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

CLINICAL CRITERIA: Applicable boxes below must be checked to ensure authorization process will NOT be delayed.

1) **Grastek®** – ***Quantity Limit = 1sublingual tablet per day***
   - Patient is between **5 through 65** years of age? ❑ Yes ❑ No
   - Diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis, **AND** ❑ Yes ❑ No
   - Has a confirmed positive skin test or *in vitro* testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens, **AND** ❑ Yes ❑ No
   - Has had a treatment failure with or contraindication to antihistamines and montelukast; **AND** ❑ Yes ❑ No
   - Clinical reason as to why allergy shots cannot be used: _____

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2) **Oralair®**
   - Patient is between **10 through 65** years of age? **AND** ❑ Yes ❑ No
   - Diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis, **AND** ❑ Yes ❑ No
   - Has a confirmed positive skin test or *in vitro* testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens; **AND** ❑ Yes ❑ No
   - Has had a treatment failure with or contraindication to antihistamines and montelukast; **AND** ❑ Yes ❑ No
   - Clinical reason as to why allergy shots cannot be used: _____

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3) **Ragwitek®**
   - Patient is between **18 through 65** years of age**; AND**? ❑ Yes ❑ No
   - Diagnosis of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; , **AND** ❑ Yes ❑ No
   - Has had a confirmed positive skin test or *in vitro* testing for pollen-specific IgE antibodies for short ragweed pollen; ❑ Yes ❑ No **AND**
   - Has had a treatment failure with or contraindication to antihistamines and montelukast; **AND** ❑ Yes ❑ No
   - Clinical reason as to why allergy shots cannot be used: _____

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****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 7/1/2018**