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 authorization process.***

Drug Requested: Odactra™ House Dust Mite (*Dermatophagoides farina* & *Dermatophagoides pteronyssinus*) Allergen Extract Sublingual Tablet ***(Non-Preferred)***

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

Drug Form/Strength/Month: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

***CLINICAL CRITERIA:* All boxes below MUST be checked to qualify. All chart notes documenting therapy trials and failures MUST be attached to this request form Authorization process will be delayed if boxes are NOT checked and chart notes are not provided.**

- ❑ Member must be 18 years of age or older

AND

- ❑ Member must have a confirmed diagnosis of house dust mite-induced allergic rhinitis, with or without conjunctivitis

AND

- ❑ Diagnosis must have been confirmed by one of the following ***(labs and/or test results must be submitted):***
  - ***In vitro*** testing for IgE antibodies to ***Dermatophagoides farina* or *Dermatophagoides pteronyssinus*** house dust mites

OR

  - Skin testing to licensed house dust mite allergen extracts

AND

- ❑ Member must have had unsuccessful ***30 day trial*** of an intranasal corticosteroid **(such as fluticasone propionate or budesonide nasal spray)** and ***one (1)*** of the following ***(Chart notes documenting therapy trials and failures must be submitted):***
  - Leukotriene inhibitor ***(such as montelukast or zafirlukast)***

OR

  - Oral antihistamine ***(such as loratadine, cetirizine or fexofenadine)***

AND

- ❑ Provider must prescribe auto-injectable epinephrine

AND

- ❑ Please note: if member has a history of any of the following ***(request will be denied if noted as yes):***
  - ❑ Severe, unstable or uncontrolled asthma ❑ Yes ❑ No
  - ❑ Eosinophilic esophagitis ❑ Yes ❑ No
  - ❑ Severe local reaction to sublingual allergen immunotherapy ❑ Yes ❑ No
  - ❑ Concurrent use of another allergen immunotherapy with Odactra ❑ Yes ❑ No

(signature on next page; must be filled out prior to submitting)

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 2/15/2018
REVISED/UPDATED: 7/1/2018