OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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)

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

Non-Preferred Medication (requires PA)

❑ Grastek® SL (**Quantity Limit – 1 sublingual tablet/day**)	❑ Oralair® SL	❑ Ragwitek® SL	❑ Odactra® HDM **(see separate form on Optima Medicaid website)**

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

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

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

CLINICAL CRITERIA: Applicable boxes below **must** be checked or authorization process will be delayed.

1) **Grastek®:** Does the patient have a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis? ❑ Yes ❑ No
   a. If **YES**, submit evidence of a confirmed positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens.

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2) **Oralair®:** Does the patient have a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis? ❑ Yes ❑ No
   a. If **YES**, submit evidence of 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.

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3) **Ragwitek®**: Does the patient have a diagnosis of short ragweed pollen-induced allergic rhinitis with or without conjunctivitis? ❑ Yes ❑ No
   a. If YES, submit evidence of a confirmed positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen.

4) Has the patient had a treatment failure with (or contraindication) to antihistamines (e.g., diphenhydramine, loratadine, etc.) and Montelukast/Singular®?

   Document details: _____

   _____

   _____

(continued on next page)

5) Is there a clinical reason why the patient cannot use allergy shots? ❑ Yes ❑ No

Document details: _____

_____

_____

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:** ~~7/6/2017; 8/28/2017; 8/15/2018; 10/24/2018;~~ **11/13/2018**;