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	❑ Oralair® SL	❑ Ragwitek® SL

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® – 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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(continued on next page)

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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_____

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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:** ~~7/6/2017; 8/28/2017;~~ **8/15/2018**