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 authorization process**.

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

(continued on next page)

- ❑ 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

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;~~ **8/28/2018**;