

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Non-Preferred Medication (requires PA)

<input type="checkbox"/> Grastek® SL	<input type="checkbox"/> Oralair® SL	<input type="checkbox"/> Ragwitek® SL
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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 = 1 sublingual 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; **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: _____

****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 #: _____