OPTIMA HEALTH PLAN

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: **Grastek®** (Timothy Grass Pollen Extract)

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

Drug Form/Strength/Month: _____

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

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

- ***Grass pollen-mid May to July. Grastek® indicated between ages of 5-65.***
- ***Only 1 allergen immunotherapy product can be approved per every 3 years (i.e. Oralair®, Ragwitek®, Grastek® or SQ allergy shots). The duration of the Authorizations will be for a 6 month period in 3 consecutive years.***
- ***Authorizations will NOT be approved for 365 consecutive days in a year.***

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. If not checked, authorization process will be delayed.

Please send skin test or In vitro testing for pollen-specific IgE antibodies results to any of the five grass species (i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass meadow fescue, or Redtop).

- ***One tablet daily. Initiate treatment at least 12 weeks before the expected onset of each grass pollen season and continue treatment throughout the season.***

❑ **Diagnosis has been documented by one of the following:**

- ❑ Positive pollen specific Skin prick test for Pooideae subfamily

OR

- ❑ Positive pollen-specific IgE antibodies for a grass in the Pooideae subfamily of grasses

❑ **Trial and Failure:**

- ❑ Patient has had ***2 paid prescriptions*** within the previous season for Intranasal Steroids (INS) and the ***look back is 12 months.***
- ❑ Grastek® may ***not*** be approved for the following:
  - ❑ Receiving concomitant therapy with other allergen immunotherapy products
  - ❑ History of severe, unstable or uncontrolled asthma: ***(Claims documenting Xolair + med/high dose of an inhaled corticosteroid/Long acting beta agonist on file)***
  - ❑ History of severe systemic allergic reaction ***(Claims documenting Hereditary Angioedema (HAE) medications, etc.)***
  - ❑ History of eosinophilic esophagitis

❑ **Prescribe auto-injectable epinephrine**

(signature on next page)

Medication being provided by a Specialty Pharmacy:	❑ **Briova SpecialtyRx**

*****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**: 2/19/2015
REVISED/UPDATED: ~~3/2/2015~~; ~~3/6/2015~~; ~~3/10/2015~~; ~~4/1/2015~~; ~~4/15/2015~~; ~~5/21/2015~~; ~~12/27/2015~~; ~~8/12/2016~~; ~~9/22/2016~~; ~~11/29/2016~~; ~~12/12/2016~~; ~~9/14/2017~~; **10/6/2017**