

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: **Oralair®**

(Sweet Vernal, Orchard Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen 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. **Oralair® indicated between ages of 10-65.**
- Only one (1) allergen immunotherapy product can be approved at a time (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).

- Initiate treatment at least 4 months (16 weeks) before the expected onset of each grass pollen season and maintain it throughout the grass pollen season.

Has the patient tried and failed Grastek®? Yes No

Please give reason for contraindication: _____

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.**

Oralair® 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; 4/1/2015; 4/15/2015; 5/22/2015; 12/29/2015; 9/22/2016; 11/29/2016; 12/13/2016; 9/16/2017; 10/7/2017.