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: **Ragwitek®** (Short Ragweed Pollen 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:*** _____

- ***Ragwitek® pollen-mid August to October. Ragwitek® indicated between ages 18-65 years old.***
- ***Only one (1) allergen immunotherapy products can be approved at a time. Example: 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.

- ❑ **Diagnosis has been documented by one of the following:**
  - ❑ Positive pollen specific skin prick test for Ragwitek® ragweed pollen antigen or cross-reactive allergen

    OR
  - ❑ Positive in vitro testing for pollen-specific IgE antibodies for Ragwitek® ragweed pollen antigen or cross reactive allergen

Please send skin test or In vitro testing for pollen-specific IgE antibodies

- ❑ **Trial and Failure of:** ***(paid pharmacy claims during 12-months look back)***
  - ❑ Nasal Steroid ***(at least 2 fills within the season)***
- ❑ Ragwitek® 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**

***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~~; ~~4/1/2015~~; ~~4/15/2015~~; ~~5/22/2015~~; ~~12/29/2015~~; ~~8/11/2016~~; ~~9/22/2016~~; ~~11/29/2016~~; ~~12/13/2016~~; ~~9/16/2017~~; **10/7/2017**