

# 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.

**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 (check applicable box below):**

**For Optima Commercial Members:**

PropriumRx

**For Optima Family Care Members:**

Sentara Norfolk General CM Pharmacy

**\*\*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; 12/11/2016; 8/3/2017.