

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: Odactra™ House Dust Mite (*Dermatophagoides farina* & *Dermatophagoides pteronyssinus*) Allergen Extract Sublingual Tablet

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength/Month: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

CLINICAL CRITERIA: All boxes below **MUST** be checked to qualify. All chart notes documenting therapy trials and failures **MUST** be attached to this request form Authorization process will be delayed if boxes are **NOT** checked and chart notes are not provided.

- Member must be 18 years of age or older

AND

- Member must have a confirmed diagnosis of house dust mite-induced allergic rhinitis, with or without conjunctivitis

AND

- Diagnosis must have been confirmed by one of the following (*labs and/or test results must be submitted*):
- *In vitro* testing for IgE antibodies to *Dermatophagoides farina* or *Dermatophagoides pteronyssinus* house dust mites

OR

- Skin testing to licensed house dust mite allergen extracts

AND

- Member must have had unsuccessful **30 day trial** of an intranasal corticosteroid (such as fluticasone propionate or budesonide nasal spray) and **one (1)** of the following (*Chart notes documenting therapy trials and failures must be submitted*):

- Leukotriene inhibitor (such as montelukast or zafirlukast)

OR

- Oral antihistamine (such as loratadine, cetirizine or fexofenadine)

AND

- Provider must prescribe auto-injectable epinephrine

AND

- Please note: if member has a history of any of the following (*request will be denied if noted as yes*):

- | | | |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Severe, unstable or uncontrolled asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Eosinophilic esophagitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Severe local reaction to sublingual allergen immunotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Concurrent use of another allergen immunotherapy with Odactra | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

(signature on next page; must be filled out prior to submitting)

****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: 2/15/2018
REVISED/UPDATED: 6/17/2018**