

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 (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; 4/1/2015; 4/15/2015; 5/22/2015; 12/29/2015; 8/11/2016; 9/22/2016; 12/11/2016; 8/4/2017; 9/16/2017.