

Grastek[®] Prior Authorization Request Form

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
<p>Select if the diagnosis has been documented by one of the following:</p> <p><input type="checkbox"/> Positive pollen specific skin prick test for Pooideae subfamily</p> <p><input type="checkbox"/> Positive pollen-specific IgE antibodies for a grass in the Pooideae subfamily of grasses</p> <p>Please provide skin test or in vitro testing results for pollen-specific IgE antibodies to any of the five grass species (i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass meadow fescue, or Redtop) along with this fax</p>					
<p>Clinical information:</p> <p>Has the treatment been initiated at least 12 weeks before the expected onset of each grass pollen season and continued treatment throughout the season? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient had a trial and failure of a nasal steroid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Paid pharmacy claims of at least 2 prescriptions within the previous season is required during a 12-month look back</i></p> <p>Is the patient receiving concomitant therapy with other allergen immunotherapy products? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a history of severe, unstable or uncontrolled asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Claims documenting Xolair and medium/high dose of an inhaled corticosteroid/long acting beta agonist on file</i></p> <p>Does the patient have a history of severe systemic allergic reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Claims documenting Hereditary Angioedema (HAE) medications, etc.</i></p> <p>Does the patient have a history of eosinophilic esophagitis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has an auto-injectable epinephrine been prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>Medication being provided by: (Please check applicable box below)</p> <p><input type="checkbox"/> PropriumRx <input type="checkbox"/> Specialty Pharmacy (specify name): _____</p>					
<p>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</p> <p>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</p>					
Prescriber Signature: _____			Date: _____		

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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