Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Odactra® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ House dust mite-induced allergic rhinitis, with or without conjunctivitis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the diagnosis was confirmed by the following:

- ❑ In vitro testing for IgE antibodies to *Dermatophagoides farina* or *Dermatophagoides pteronyssinus* house dust mites
- ❑ Skin testing to licensed house dust mite allergen extracts

Labs and/or test results must be submitted

Select if the patient had an unsuccessful 30 day trial of the following:

- ❑ Intranasal corticosteroid (such as fluticasone propionate or budesonide nasal spray)
- ❑ Leukotriene inhibitor (such as montelukast or zafirlukast)
- ❑ Oral antihistamine (such as loratadine, cetirizine or fexofenadine)

Chart notes documenting therapy trials and failures must be submitted

Has an auto-injectable epinephrine been prescribed by the provider? ❑ **Yes** ❑ **No**

Select if the patient has a history of the following:

- ❑ Concurrent use of another allergen immunotherapy with Odactra
- ❑ Eosinophilic esophagitis
- ❑ Severe local reaction to sublingual allergen immunotherapy
- ❑ Severe, unstable or uncontrolled asthma

Quantity limit requests:

What is the quantity requested per DAY? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

** *Please note: Chart documentation of the above is required to be submitted along with this fax*

_____

_____

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Odactra® Prior Authorization Request Form (Page 2 of 2)

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Chart notes and any lab results MUST be submitted with this request.
****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.

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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