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

Oralair® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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 if the diagnosis has been documented by one of the following:

❑ Positive pollen specific skin prick test for Pooideae subfamily

❑ Positive pollen-specific IgE antibodies for a grass in the Pooideae subfamily of grasses

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

Clinical information:

Has the treatment been initiated at least 4 months (16 weeks) before the expected onset of each grass pollen season and maintained throughout the grass pollen season? ❑ **Yes** ❑ **No**

Has the patient tried and failed Grastek? ❑ **Yes** ❑ **No**

Please give reason for contraindication**:** _____

_____

Has the patient had a trial and failure of a nasal steroid? ❑ **Yes** ❑ **No**

Paid pharmacy claims of at least 2 prescriptions within the previous season is required during a 12-month look back

Is the patient receiving concomitant therapy with other allergen immunotherapy products? ❑ **Yes** ❑ **No**

Does the patient have a history of severe, unstable or uncontrolled asthma? ❑ **Yes** ❑ **No**

Claims documenting Xolair and medium/high dose of an inhaled corticosteroid/long acting beta agonist on file

Does the patient have a history of severe systemic allergic reaction? ❑ **Yes** ❑ **No**

Claims documenting Hereditary Angioedema (HAE) medications, etc.

Does the patient have a history of eosinophilic esophagitis? ❑ **Yes** ❑ **No**

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

Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.