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

Ragwitek® 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** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

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

❑ Positive pollen specific skin prick test for Ragwitek ragweed pollen antigen or cross-reactive allergen

❑ Positive in-vitro testing for pollen-specific IgE antibodies for Ragwitek ragweed pollen antigen or cross reactive allergen

Please provide skin test or in vitro testing results for pollen-specific IgE antibodies along with this fax

Clinical information:

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

Paid pharmacy claims of at least 2 fills within the 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?

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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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**