IOWA Health and Human Services

Request for Prior Authorization
ORAL IMMUNOTHERAPY

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Medication is prescribed by or in consultation with an allergist or immunologist; and**
3. **Patient has documentation of an adequate trial and therapy failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently; and**
4. **Patient has a documented intolerance to immunotherapy injections; and**
5. **The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration.**
6. **If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.**

Non-Preferred

☐ Grastek ☐ Oralair ☐ Ragwitek

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Is prescriber an allergist or immunologist? ☐ Yes ☐ No (If no, note consultation with allergist or immunologist)

Consultation Date:_____ Physician Name & Phone: _____

Does patient have a documented intolerance to immunotherapy injections? ☐ Yes ☐ No

If yes, please describe: _____

Has first dose been administered under the supervision of a health care provider? ☐ Yes ☐ No

If yes: Date:_____ Response: _____

Does patient receive other subcutaneous immunotherapy: ☐ Yes ☐ No

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Treatment failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently:

Intranasal Corticosteroid Name & Dose:_____Trial dates: _____

Reason for failure: _____

Antihistamine Name & Dose:_____Trial dates: _____

Reason for failure: _____

☐ **Short Ragweed Pollen (Ragwitek) in addition to the above criteria being met:**

Patient is diagnosed with short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis: ☐ Yes ☐ No

Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen:

☐ Yes (attach results) ☐ No

If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.

☐ **Grass Pollen (Grastek and Oralair) in addition to the above criteria being met:**

1. Request is for Grastek; and

Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis: ☐ Yes ☐ No

Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop):

☐ Yes (attach results) ☐ No

If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of grass pollen season as follows:

- Seasonally, through the end of the grass pollen season; or
- For sustained effectiveness, up to three consecutive years (including the intervals between grass pollen seasons) for one grass pollen season after cessation of treatment. Authorizations would be given in 12-month intervals up to three consecutive years with one grass pollen season.

2. Request is for Oralair; and

Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis: ☐ Yes ☐ No

Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, Kentucky blue/June grass:

☐ Yes (attach results) ☐ No

If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season.

☐ **House Dust Mite (Odactra) in addition to the above criteria being met:**

Patient is diagnosed with house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis: ☐ Yes ☐ No

Patient has a positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to

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Dermatophagoides farina or Dermatophagoides pteronyssinus house dust mites:

☐ Yes (attach results) ☐ No

If criteria for coverage are met, authorization will be considered for 12 months.

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*