







FAX Completed Form To 1.833.404.2392

Pharmacy Help Desk 1.800.460.8988

Prescriber Help Desk 1.833.587.2012

Request for Prior Authorization ORAL IMMUNOTHERAPY

(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		
with pollen-induced allergic rhini therapy failures with allergen avoid and 4) Patient has a documented administered under the supervisiadministration and response require subcutaneous allergen immunoti immunotherapy (SLIT) will not be least 12 weeks before the expect for Oralair. Non-Preferred	oidance and pharmacotherapy intolerance to immunotheraption of a health care provider to uired prior to consideration. therapy (SCIT), treatment of all a approved. If criteria for cove	y (intranasal corticosto by injections; and 5) To o observe for allergic 6) If patient receives of lergic rhinitis with sub erage are met, authoric	eroids and antihistamines); the first dose has been reactions (date of ther immunotherapy by blingual allergen zation will be considered at	
	Dralair □ Rao	gwitek		
Strength	Dosage Instructions	Quantity	Days Supply	
Diagnosis:				
Is prescriber an allergist?	∕es ☐ No (If no, note consul	tation with allergist)		
Consultation Date:	Physician Name & Phone:			
Does patient have a documented	intolerance to immunotherap	y injections?	☐ Yes ☐ No	
If yes, please describe:				
Has first dose been administered	l under the supervision of a h	ealth care provider?	☐ Yes ☐ No	
If ves: Date:	Response:			

1 of 2 Rev. 4/19









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Does patient receive other subcutaneous inimunotherapy. Tes	INO			
Treatment failure with allergen avoidance and pharmacotherapy (intranas	al corticosteroids and antihistamines):			
Intranasal Corticosteroid Name & Dose:	Trial dates:			
Reason for failure:				
Antihistamine Name& Dose:	Trial dates:			
Reason for failure:				
Allergen Avoidance Measures:				
Ragwitek (in addition to above)				
Requests for Ragwitek will be considered for patients 18 through 65 y	rears of age.			
Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen:				
☐ Yes (attach results) ☐ No				
☐ Grastek (in addition to above):				
Requests for Grastek will be considered for patients 5 through 65 year	rs of age.			
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				
☐ Oralair (in addition to above):				
Requests for Oralair will be considered for patients 10 through 65 year	rs of age.			
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				
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 Human Services, that the member continues to be eligible for Medicaid.