SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed.**

Oral Anti-Allergens (Non-Preferred)

Drug Requested: (Check below the drug that applies)

❑ **Grastek®**	❑ **Odactra®**	❑ **Oralair®**	❑ **Ragwitek™**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINCIAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Approval Length: 1 Year

1. For **Grastek®:** Does the patient have a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis? ❑ Yes ❑ No

(Continued on next page)

2. For **Odactra®**: Does the patient have a diagnosis of house dust mite (HDM)-induced allergic rhinitis with or without conjunctivitis? ❑ Yes ❑ No
3. For **Oralair®:** Does the patient have a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis? ❑ Yes ❑ No
4. **Ragwitek™:** Does the patient have a diagnosis of short ragweed pollen-induced allergic rhinitis with or without conjunctivitis? ❑ Yes ❑ No
5. Has the patient had a treatment failure with (or contraindication) to antihistamines (eg.,diphenhydramine, loratadine, etc.) AND montelukast/Singulair®? ❑ Yes ❑ No
6. Is there a clinical reason why the member cannot use allergy shots? ❑ Yes ❑ No

Document details: _____

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claimsor submitted chart notes.