AvMed

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 1-305-671-0200.** 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 may be delayed.**

Drug Requested: (select **ONE** of the following)

❑ **Grastek®** (Timothy Grass Pollen Extract)	❑ **Oralair®** (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen Extract)

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

Member Name: _____

Member AvMed #: _____ **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:** _____

Weight: _____ **Date:** _____

Recommended Dosage: Dissolve one tablet under the tongue daily for 3 consecutive years

- **Grass pollen season = Mid May to July; the duration of authorization will be for a 12-month period and will remain active for 3 consecutive years**
- **Only 1 grass allergen-specific immunotherapy product can be approved for use at a time (i.e., Oralair®, Grastek® or SQ allergy shots)**

CLINICAL 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.

Length of Authorization: 3 years

❑ Medication is prescribed by or in consultation with an allergist or immunologist

(Continued on next page)

- ❑ Member must meet **ONE** of the following age requirements:
  - ❑ For Grastek requests: Member must be between the ages of 5 and 65 years old
  - ❑ For Oralair requests: Member must be between the ages of 10 and 65 years old
- ❑ Member must meet **ONE** of the following treatment initiation requirements:
  - ❑ For Grastek requests: Treatment will be initiated at least 12 weeks before the expected onset of each grass pollen season and will be continued throughout the grass pollen season
  - ❑ For Oralair requests: Treatment will be initiated at least 16 weeks before the expected onset of each grass pollen season and will be continued throughout the grass pollen season
- ❑ Member has a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by **ONE** of the following [skin test or in vitro testing for pollen-specific IgE antibodies results to any of the following five grass species (i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass meadow fescue, or Redtop) **must** be submitted with request]:
  - ❑ Positive skin prick test for at least one grass pollen contained in requested medication
  - ❑ Positive in vitro testing for pollen-specific IgE antibodies for at least one grass pollen contained in requested medication
- ❑ Member has had trial and inadequate symptom control with at least **TWO** of the following within the past 12 months **(verified by chart notes or pharmacy paid claims)**:
  - ❑ Intranasal corticosteroid (e.g., fluticasone, budesonide, triamcinolone)
  - ❑ Intranasal antihistamine (e.g., azelastine, olopatadine)
  - ❑ Oral antihistamine (e.g., levocetirizine)
  - ❑ Leukotriene inhibitor (e.g., montelukast, zafirlukast)
- ❑ Provider has prescribed auto-injectable epinephrine **(verified by chart notes or pharmacy paid claims)**
- ❑ Provider attests that member does **NOT** have any of the following:
  - Receiving concomitant therapy with other allergen immunotherapy products (review claims for documenting concurrent use of Oralair, Grastek)
  - History of severe, unstable or uncontrolled asthma: (review claims documenting Xolair + med/high dose of an inhaled corticosteroid/Long-acting beta agonist on file)
  - History of severe systemic allergic reaction (review claims documenting Hereditary Angioedema (HAE) medications)
  - History of eosinophilic esophagitis

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****