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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Odactra® House Dust Mite (Dermatophagoides farinae and Dermatophagoides pteronyssinus) **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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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

- The duration of authorization will be for a 12-month period and will remain active for 3 consecutive years

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
- ❑ Member must be between the ages of 5 and 65 years old

(Continued on next page)

- ❑ Member has a diagnosis of house dust mite-induced allergic rhinitis, with or without conjunctivitis confirmed by **ONE** of the following (skin test or in vitro testing for house dust mite-specific IgE antibodies results **must** be submitted with request):
  - ❑ Positive skin prick test to licensed house dust mite allergen extracts
  - ❑ Positive in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites
- ❑ 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 chart notes for documentation of concurrent use of allergy shots)
  - 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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~2/15/2018; 2/16/2023;~~ **3/27/2025**
REVISED/UPDATED/REFORMATTED: ~~6/17/2018; 6/19/2019; 3/3/2023; 10/30/2023;~~ **4/15/2025**