maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Grastek/Oralair

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient greater than or equal to 5 year(s) of age? [If no, no further questions.]	Yes	No
2	Will the requested medication be used in combination with subcutaneous (SC) allergen immunotherapy (for example, allergy shots) or other sublingual (SL) allergen immunotherapy (for example, Odactra, Ragwitek)? [If yes, no further questions.]	Yes	No
3	Has the diagnosis of grass pollen-induced allergic rhinitis (AR) been confirmed by a positive skin test response to a grass pollen from the Pooideae subfamily of grasses? [If yes, skip to question 5.]	Yes	No

If you have any questions, call:
1-888-258-8250

PRIOR AUTHORIZATION REQUEST

	[NOTE: This includes, but is not limited to sweet vernal, Kentucky blue grass, Timothy grass, orchard, or perennial rye grass.]		
4	Has the patient had a positive in vitro test (for example; a blood test) for allergen-specific immunoglobulin E (IgE) antibodies for a grass in the Pooideae subfamily of grasses? [If no, no further questions.] [NOTE: This includes, but is not limited to sweet vernal, Kentucky blue grass, Timothy grass, orchard, or perennial rye grass.]	Yes	No
5	What medication is being requested? [] Grastek (If checked, go to 6) [] Oralair (If checked, go to 7)		
6	Is Grastek being initiated 12 weeks prior to the expected onset of the grass pollen season or therapy is being dosed daily continuously for consecutive grass pollen seasons? [No further questions.] [NOTE: The grass pollen season generally begins between March and May and varies by geographical location.]	Yes	No
7	Is Oralair being initiated 4 months prior to the expected onset of the grass pollen season? [NOTE: The grass pollen season generally begins between March and May and varies by geographical location.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.