



# 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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy?	
	<input type="checkbox"/> Initial (If checked, go to 6)	
	<input type="checkbox"/> Continuation (If checked, go to 2)	
2	Is the patient currently receiving the requested medication? [If no, go to question 6.]	Yes      No

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3	Has the patient been receiving medication samples? [If yes, go to question 6.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [If no, skip to question 6.]	Yes	No
[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]			
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
6	Is the patient greater than or equal to 5 year(s) of age? [If no, no further questions.]	Yes	No
7	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
8	Is the requested medication being prescribed by or in consultation with an allergy specialist? [If no, no further questions.]	Yes	No
9	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 11.]	Yes	No
[NOTE: This includes, but is not limited to sweet vernal, Kentucky blue grass, Timothy grass, orchard, or perennial rye grass.]			
10	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.]	Yes	No
[NOTE: This includes, but is not limited to sweet vernal, Kentucky blue grass, Timothy grass, orchard, or perennial rye grass.]			
11	What medication is being requested? <input type="checkbox"/> Grastek (If checked, go to 12)		

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Oralair (If checked, go to 14)

12 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? Yes No  
[If no, no further questions.]

[NOTE: The grass pollen season generally begins between March and May and varies by geographical location.]

13 Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Yes No  
[No further questions.]

[Note: Dosing for adults: 372 mg every 8 hours for 6 doses; Maintenance: 372 mg once daily. Dosing for pediatrics: weight based dosing.]

14 Is Oralair being initiated 4 months prior to the expected onset of the grass pollen season? Yes No  
[If no, no further questions.]

[NOTE: The grass pollen season generally begins between March and May and varies by geographical location.]

15 Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Yes No

[Dosing: Adults less than or equal to 65 years: 300 IR once daily; Children greater than or equal to 5 years and Adolescents less than or equal to 17 years: Day 1: 100 IR once daily; Day 2: 200 IR once daily; Maintenance (Day 3 and thereafter): 300 IR once daily]

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

## **SECTION B:** Physician Signature

PHYSICIAN SIGNATURE

DATE

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**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 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.

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