AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Oral Immunotherapy

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions: 1) Medication is prescribed in consultation with an allergist; and 2) Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and 3) Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and 4) Patient has a documented intolerance to immunotherapy injections; and 5) The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration. 6) If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of the specific allergen season for Grastek and Ragwitek and 4 months for Oralair.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred:

☐ **Grastek** ☐ **Oralair** ☐ **Ragwitek**

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Is prescriber an allergist? ☐ Yes ☐ No (If no, note consultation with allergist)

Consultation Date: Physician Name and Phone:

Does patient have a documented intolerance to immunotherapy injections? ☐ Yes ☐ No

If yes, please describe:

Has first dose been administered under the supervision of a health care provider? ☐ Yes ☐ No

If yes:

Date: Response:

AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Oral Immunotherapy

Please print – accuracy is important.

Does patient receive other subcutaneous immunotherapy: ☐ Yes ☐ No

Treatment failure with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines):

Intranasal Corticosteroid Name & Dose: Trial dates:

Reason for failure:

Antihistamine Name & Dose: Trial dates:

Reason for failure:

Allergen Avoidance Measures:

☐ **Ragwitek (in addition to above)**

Requests for Ragwitek will be considered for patients 18 through 65 years of age.

Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen:

☐ Yes (attach results) ☐ No

☐ **Grastek (in addition to above):**

Requests for Grastek will be considered for patients 5 through 65 years of age.

Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop):

☐ Yes (attach results) ☐ No

☐ **Oralair (in addition to above):**

Requests for Oralair will be considered for patients 10 through 65 years of age.

Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, Kentucky blue/June grass:

☐ Yes (attach results) ☐ No

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.