Gateway Health℠ It's Wholecare.

Updated: 02/2021
PARP Approved: 03/2021

Prior Authorization Criteria

Sublingual Allergy Immunotherapy

All requests for Sublingual Allergy Immunotherapy require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Sublingual Allergy Immunotherapy include Oralair (Sweet Vernal, Orchard, Perennial Rye, Timothy, Kentucky Blue Grass Mixed Pollens Allergen Extract) and Odactra (House Dust Mite Allergen Extract). New products with this classification will require the same documentation.

For all requests the following criteria must be met in addition to the diagnosis specific criteria below:

- Medication must be prescribed by or in consultation with an allergist, immunologist, or otolaryngologist
- Member must have a history of trial and failure, contraindication, or intolerance of at least 1 month to at least two of the following:
    - Intranasal corticosteroid (e.g. fluticasone)
    - Oral non-sedating antihistamine, intranasal antihistamine (e.g. loratadine, levocetirizine, cetirizine)
    - Oral leukotriene receptor antagonist (montelukast)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of **grass pollen-induced allergic rhinitis** with or without conjunctivitis and the following criteria is met:

- Medication is Oralair
- Member is 5 to 65 years old.
- The diagnosis is confirmed by ONE of the following within the past 2 years:
    - Positive skin test to any of the following allergens: Sweet vernal, orchard, perennial rye, Timothy or Kentucky grass
    - IgE specific antibodies to any of the following allergens: Sweet vernal, orchard, perennial rye, Timothy or Kentucky grass
- Treatment should be initiated 4 months prior to grass season typically occurring during the summer months, starting in May. Treatment should NOT be initiated mid-season.
- **Initial Duration of Approval:** January 1 through September 30
- **Reauthorization criteria**
    - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment
- **Reauth Duration of Approval:** January 1 through September 30

Coverage may be provided with a diagnosis of **house dust mite (HDM)-induced allergic rhinitis** with or without conjunctivitis and the following criteria is met:

- Medication is Odactra
- Member is age 18 to 65 years old.
- The diagnosis is confirmed by ONE of the following within the past 2 years:

  - Positive skin test to licensed house dust mite allergen extracts.
  - IgE specific antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment
- **Reauth Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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SUBLINGUAL ALLERGY IMMUNOTHERAPY PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Gateway ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Which allergies does the member have? Check all that apply:

☐ Timothy grass pollen
☐ Sweet vernal, orchard, perennial rye, Timothy or Kentucky grass
☐ Short ragweed pollen
☐ House dust mite

How was the diagnosis confirmed? ☐ Positive skin test ☐ Presence of IgE specific antibodies

Which of the following have been tried?

☐ Intranasal corticosteroid
☐ Oral or intranasal antihistamine
☐ Leukotriene receptor antagonist (montelukast)

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date