PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Oral Immunotherapy - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Oral Immunotherapy - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Grastek (timothy grass pollen allergen extract)	Oralair (grass mixed pollen ext)	Ragwitek (ragweed pollen allergen extract)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for Grastek? Y N

[If no, then skip to question 4.]

2. Is this request for the treatment of grass pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass pollen? Y N _____

[Note: Documentation must be submitted.]

	[If no, then no further questions.]		
3.	Is the patient between 8 and 65 years of age?	Y N	
	[If yes, then skip to question 10.]		
	[If no, then no further questions.]		
4.	Is this request for Oralair?	Y N	
	[If no, then skip to question 7.]		
5.	Is this request for the treatment of grass pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy and Kentucky Blue Grass mixed pollens?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
6.	Is the patient between 10 and 65 years of age?	Y N	
	[If yes, then skip to question 10.]		
	[If no, then no further questions.]		
7.	Is this request for Ragwitek?	Y N	
	[If no, then no further questions.]		
8.	Is this request for the treatment of short ragweed pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
9.	Is the patient between 18 and 65 years of age?	Y N	
	[If no, then no further questions.]		
10.	Has the patient tried and failed Singulair (montelukast), as well as one oral antihistamine and one intranasal steroid?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
11.	Does the patient have any of the following: A) Known hypersensitivity to any oral extracts and their components, B) Severe, unstable, or uncontrolled asthma, C) Non-responsive to epinephrine or inhaled bronchodilators, D) Concomitant allergen immunotherapy?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date