Prior Authorization Request Form for

house dust mite allergen extract (Odactra)

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________

Address: ____________________ Address: ____________________

____________________ ____________________

Sponsor ID # ____________________ Phone #: ____________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Odactra*	☐ Yes (subject to verification) Proceed to question **16**	☐ No Proceed to question **2**
2. Is the requested medication being prescribed by an allergist/immunologist?	☐ Yes Proceed to question **3**	☐ No **STOP Coverage not approved**
3. Is the patient between the ages of 18 and 65 years of age?	☐ Yes Proceed to question 4	☐ No **STOP Coverage not approved**
4. Does the patient have a diagnosis of house dust mite (HDM) allergic rhinitis?	☐ Yes Proceed to question **5**	☐ No **STOP Coverage not approved**
5. Has the diagnosis been confirmed with either a positive skin test or an in vitro test for pollen-specific for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites?	☐ Yes Proceed to question **6**	☐ No **STOP Coverage not approved**
6. Does the have patient also have a diagnosis of allergic asthma?	☐ Yes Proceed to question **7**	☐ No Proceed to question **9**
7. Has the patient responded to an adequate trial of inhaled steroids?	☐ Yes **STOP Coverage not approved**	☐ No Proceed to question **8**

8. Is the patient's FEV1 GREATER THAN 70 percent?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
9. Has the patient's allergic rhinitis symptoms been controlled with a nasal corticosteroid (e.g., fluticasone)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Has the patient's allergic rhinitis symptoms been controlled with at least one of the following: • **oral antihistamine,** • **nasal antihistamines, or a** • **leukotriene receptor antagonist (montelukast)?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Provider is aware of boxed warning requiring monitoring of all patients for at least 30 minutes after INITIAL dose in a healthcare setting due to potential allergic reaction and agrees to administer and monitor the patient taking the first dose?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have a prescription for self-administered SC epinephrine?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient have a history of severe local allergic reaction to sublingual immunotherapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Is the patient receiving co-administered SC immunotherapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **15**
15. Does the patient have severe, uncontrolled, unstable asthma?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
16. Has the patient responded positively to treatment and is not receiving co-administered SC immunotherapy?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Does the patient have severe, uncontrolled, unstable asthma?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________________ Prescriber Signature   ______________ Date

[19 November 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: