



Prior Authorization
<p>JOHNS HOPKINS HEALTHCARE (MEDICAID) Oral Immunotherapy - Priority Partners MCO</p> <p>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 Healthcare at 1-410-424-4607. Please contact Johns Hopkins Healthcare at 1-888-819-1043 with questions regarding the Prior Authorization process.</p> <p>When conditions are met, we will authorize the coverage of Oral Immunotherapy - Priority Partners MCO.</p>

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: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Is this request for Grastek?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	

[If no, then no further questions.]	
3. Is the patient between 8 and 65 years of age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, then skip to question 10.]	
[If no, then no further questions.]	
4. Is this request for Oralair?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
6. Is the patient between 10 and 65 years of age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, then skip to question 10.]	
[If no, then no further questions.]	
7. Is this request for Ragwitek?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
9. Is the patient between 18 and 65 years of age?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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.

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Prescriber (Or Authorized) Signature and Date