



Prior Authorization (PA) Form
ANTI-ALLERGENS, ORAL

If the following information is not complete, correct, or legible, the PA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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DRUG INFORMATION

Authorization 1 year

Non-preferred medications require PA:

Oralair®

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Age edit according to PI:

- Oralair can be used for children 10 and older

(Form continued on next page)

<https://mediproviders.anthem.com/va>

Member's Last Name:

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Member's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

1. **Oralair®:** Does the member have a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis?

Yes No

a. If YES, submit a positive skin test for 1 out of 5 grass pollens (e.g., Sweet Vernal, Orchard, Perennial Rye, Timothy, or Kentucky Bluegrass) or Ragweed (for Ragwitek) for pollen-specific IgE antibodies prior to administration.

2. Has the member had a treatment failure with (or contraindication) to antihistamines (e.g., diphenhydramine, loratadine, etc.) and Montelukast/Singulair®?

Yes No

Document details: _____

3. Is there a clinical reason why the member cannot use allergy shots?

Yes No

Document details: _____

4. Does the member have an auto-injectable epinephrine at home that they have been trained to use, and have they been instructed to seek immediate medical care upon its use?

Yes No

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.

The completed form may be **FAXED TO 1-844-512-7020**.