



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Grastek® Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>
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Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
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Select the diagnosis below:

Grass pollen-induced allergic rhinitis
Is the patient's condition moderate to severe? Yes No

Other diagnosis: _____ ICD-10 Code(s): _____

Confirmation of diagnosis:

Is the patient's diagnosis confirmed by a positive skin test to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky Blue/June grass, Meadow Fescue, or Redtop)? Yes No

Is the patient's diagnosis confirmed by in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky Blue/June grass, Meadow Fescue, or Redtop)? Yes No

Clinical information:

Will treatment be initiated 3 months before the expected onset of the grass pollen season? Yes No

Was Grastek prescribed by or in consultation with an allergist or immunologist? Yes No

Is the requested medication being received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Oralair)? Yes No

Does the patient have symptomatic and/or uncontrolled asthma? Yes No

Select the medications the patient has a history of failure, contraindication, or intolerance to:

Intranasal antihistamine [e.g., azelastine (Astelin)]

Intranasal corticosteroid [e.g., fluticasone (Flonase)]

Leukotriene inhibitor [e.g., montelukast (Singulair)]

Oral antihistamine [e.g., cetirizine (Zyrtec)]

Other antihistamine(s). Please specify: _____

Reauthorization:

If this is a reauthorization request, answer the following questions:

Has the patient experienced improvement in the symptoms of allergic rhinitis? Yes No

Has the patient experienced a decrease in the number of medications needed to control allergy symptoms? Yes No

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

Titration or loading-dose purposes

Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

Requested strength/dose is not commercially available

Other: _____

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Grastek_Comm_2018Mar-W



Grastek[®] Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.