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

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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

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): _____

Diagnosis confirmation:

Is the patient's diagnosis confirmed by a positive skin test to any of the five grass species including sweet vernal, orchard, perennial rye, Timothy or Kentucky blue grass mixed pollens? ❑ **Yes** ❑ **No**

Is the patient's diagnosis confirmed by a positive skin test to cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)? ❑ **Yes** ❑ **No**

Is the patient's diagnosis confirmed by in vitro testing for pollen-specific IgE antibodies to any of the five grass species including sweet vernal, orchard, perennial rye, Timothy or Kentucky blue grass mixed pollens? ❑ **Yes** ❑ **No**

Is the patient's diagnosis confirmed by in vitro testing for pollen-specific IgE antibodies for cross reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)? ❑ **Yes** ❑ **No**

Clinical information:

Will treatment be initiated 4 months before the expected onset of the grass pollen season? ❑ **Yes** ❑ **No**

Was Oralair prescribed by or in consultation with an allergist or immunologist? ❑ **Yes** ❑ **No**

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

Is Oralair being received in combination with a similar cross-reactive grass pollen immunotherapy (e.g., Grastek)? ❑ **Yes** ❑ **No**

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

❑ Intranasal antihistamine (e.g., azelastine)
❑ Intranasal corticosteroid (e.g., fluticasone)
❑ Leukotriene inhibitor (e.g., montelukast)
❑ Oral antihistamine (e.g., cetirizine)
❑ 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: _____

Oralair® 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.