**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

# Ragwitek® Prior Authorization Request Form

**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:**

❑ Short ragweed pollen-induced allergic rhinitis
Is the patient's condition moderate to severe? ❑ **Yes** ❑ **No**

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

**Clinical information:**

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

Is the patient's diagnosis confirmed by a positive skin test or in vitro test for pollen-specific IgE antibodies to short ragweed pollen? ❑ **Yes** ❑ **No**

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

Does the patient have symptomatic and/or uncontrolled asthma? ❑ **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: _____

**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.