

Member Name: _____ Member ID: _____ Member DOB: _____
 Drug Name: _____ Strength: _____ Directions: _____
 Physician Name: _____ Physician Phone #: _____ Specialty: _____
 Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Sublingual Immunotherapy (Grastek, Oralair, Ragwitek, Odactra) – Medical Necessity Request

When is member planning to start therapy (i.e., how many weeks before expected onset of pollen season)? _____

Does the member plan to continue throughout season? **Yes or No**

Contraindication Information (does the member have any of the following contraindications?):

- Severe, unstable or uncontrolled asthma
- History of any severe systemic allergic reaction
- History of any severe local reaction after taking any sublingual allergen immunotherapy
- History of Eosinophilic Esophagitis
- Hypersensitivity to any of the inactive ingredients
- None

Diagnosis Information (please indicate diagnosis and answer related questions):

1. What is member being treated for?
 - Grass pollen induced allergic rhinitis Ragweed pollen induced allergic rhinitis
 - House dust mite (HDM)-induced allergic rhinitis Other _____

2. Which specialist is prescribing the medication: Allergist Immunologist Other _____

3. Will the first dose be administered in the healthcare setting? **Yes or No**

4. Does member have an active prescription for an epinephrine injection? **Yes or No**

5. Did member have a positive skin prick test or in vitro testing for IgE antibodies? **Yes or No**
 - **If Yes**, please indicate which antibody tested positive:

<input type="checkbox"/> Sweet Vernal	<input type="checkbox"/> Timothy	<input type="checkbox"/> Dermatophagoides farina HDM
<input type="checkbox"/> Orchard	<input type="checkbox"/> Kentucky Blue Grass	<input type="checkbox"/> Dermatophagoides pteronyssinus HDM
<input type="checkbox"/> Perennial Rye	<input type="checkbox"/> Ragweed	<input type="checkbox"/> Other: _____

6. Has member tried and failed oral antihistamine(s)?
 - Yes** - Please provide the names of the medications tried: _____
 - No** – Can the member try an oral antihistamine (OTC cetirizine, OTC loratadine, Fexofenadine 60mg or 180mg, OTC Allegra-D)?
 - Yes** - please provide the name of the new medication, call the prescription for the new medication into the pharmacy, then return form to HNJH. _____
 - No** - provide the reason why member cannot try an oral antihistamine.

7. Has member tried and failed intranasal antihistamine(s)?
 - Yes** - Please provide the names of the medications tried: _____
 - No** – Can the member try an intranasal antihistamine (Generic Astelin)?
 - Yes** - please provide the name of the new medication, call the prescription for the new medication into the pharmacy, then return form to HNJH. _____
 - No** - provide the reason why member cannot try an intranasal antihistamine.

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Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

8. Has member tried and failed intranasal corticosteroid(s)?

Yes - Please provide the names of the medications tried: _____

No – Can the member try an intranasal corticosteroid (Fluticasone, OTC Nasacort 24HR)?

Yes - please provide the name of the new medication, call the prescription for the new medication into the pharmacy, then return form to HNJH. _____

No - provide the reason why member cannot try an intranasal Corticosteroid.

9. Has member tried and failed Subcutaneous Allergen Immunotherapy?

Yes

No – Can the member try Subcutaneous Allergen Immunotherapy?

Yes

No - provide the reason why member cannot try Subcutaneous Allergen immunotherapy.

Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office