Iowa Department of Human Services

Request for Prior Authorization
ORAL IMMUNOTHERAPY

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195
IOWA Provider Services
1 (844) 236-1464

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions: 1) Medication is prescribed in consultation with an allergist; and 2) Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and 3) Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and 4) Patient has a documented intolerance to immunotherapy injections; and 5) The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration. 6) If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved. If criteria for coverage are met, authorization will be considered at least 4 months before the expected onset of the specific allergen season for Oralair.

Non-Preferred

☐ Oralair

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Is prescriber an allergist? ☐ Yes ☐ No (If no, note consultation with allergist)

Consultation Date: _____ Physician Name & Phone: _____

Does patient have a documented intolerance to immunotherapy injections? ☐ Yes ☐ No

If yes, please describe: _____

Has first dose been administered under the supervision of a health care provider? ☐ Yes ☐ No

If yes: Date: _____ Response: _____

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Does patient receive other subcutaneous immunotherapy: ☐ Yes ☐ No

Treatment failure with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines):

Intranasal Corticosteroid Name & Dose: _____ Trial dates: _____

Reason for failure: _____

Antihistamine Name& Dose: _____ Trial dates: _____

Reason for failure: _____

Allergen Avoidance Measures: _____

Requests for Oralair will be considered for patients 10 through 65 years of age.

Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, Kentucky blue/June grass:

☐ Yes (attach results) ☐ No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*