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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Immunotherapy (Grastek, Oralair, Ragwitek, Odactra, Palforzia) – Medical Necessity Request

*****Complete pages 1 and 2 only for New/Initial Requests*****

General Information

1. Which specialist is managing the medication: □ Allergist □ Immunologist □ Other_____
2. Does member have an active prescription for an epinephrine injection? **Yes or No**

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

1. What is member being treated for?
   - □ Grass pollen induced allergic rhinitis
   - □ House dust mite (HDM)-induced allergic rhinitis
   - □ Other_____
   - □ Ragweed pollen induced allergic rhinitis
   - □ Peanut allergy

For Grastek, Oralair, Ragwitek, and Odactra requests:

1. **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
2. Will the first dose be administered in the healthcare setting? **Yes or No**
3. When is member planning to start therapy (i.e., how many weeks before expected onset of pollen season)?
   _____
4. Does the member plan to continue throughout season? **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:
     - □ Sweet Vernal
     - □ Orchard
     - □ Perennial Rye
     - □ Timothy
     - □ Kentucky Blue Grass
     - □ Short Ragweed
     - □ Dermatophagoides farinae HDM
     - □ Dermatophagoides pteronyssinus HDM
     - □ Other: _____
6. Has member tried and failed oral antihistamine(s)?
   - □ **Yes** - Please provide the names of the medications tried and failed:
     _____
   - □ **No** – Can the member try an oral antihistamine (OTC cetirizine, OTC loratadine, Fexofenadine 60mg or 180mg) instead?
     - □ **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 instead.
       _____
       _____

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: _____

7. Has member tried and failed intranasal antihistamine(s)?

□ **Yes** - Please provide the names of the medications tried and failed:

_____

□ **No** – Can the member try an intranasal antihistamine (Generic Astelin) instead?

□ **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 instead.

_____

_____

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

□ **Yes** - Please provide the names of the medications tried and failed:

_____

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

□ **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 instead.

_____

_____

9. Has member tried and failed Subcutaneous Allergen Immunotherapy?

□ **Yes**

□ **No** – Can the member try Subcutaneous Allergen Immunotherapy instead?

□ **Yes**

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

_____

_____

For Palforzia requests:

1. Does the member have a confirmed diagnosis of peanut allergy (e.g., positive skin prick test, or elevated Serum immunoglobulin E (IgE) level to peanut, or history of peanut allergy)? **Yes or No**

2. Does the member have a history of peanut allergy or allergy to peanut-containing foods? **Yes or No**

3. Will Palforzia be used together with peanut-avoidant diet? **Yes or No**

4. Will initial and up-dosing be administered in a health care setting? **Yes or No**

5. **Contraindication Information** (does the member have any of the following contraindications?):
   □ Uncontrolled asthma
   □ History of Eosinophilic Esophagitis or other eosinophilic gastrointestinal disease
   □ None

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: _____

Horizon NJ Health

Immunotherapy (Grastek, Oralair, Ragwitek, Odactra, Palforzia) – Medical Necessity Request

*****Complete page 3 only for Subsequent Requests*****

For Palforzia requests:

1. Does the member continue to have a peanut-free diet to avoid peanut exposure? **Yes or No**

2. Has the member had accidental peanut exposure? **Yes or No**
   a. If **Yes**, please let us know if the member has had clinical benefit with the requested agent (e.g. member has no more than mild symptoms during a food challenge, member shows reduction in severity of symptoms at any challenge dose of peanut protein, etc.)? **Yes or No**

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

4. Please let us know if the member has any of the following (check all that apply):
   - □ Member is unable to tolerate doses up to and including the 3mg dose during Initial Dose Escalation
   - □ Member has suspected eosinophilic esophagitis
   - □ Member is unable to comply with the daily dosing requirements
   - □ Member has recurrent asthma exacerbations or persistent loss of asthma control
   - □ None of the above

Physician office's signature*_____ Print Name_____

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