

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**  
**Grastek (timothy grass pollen allergen extract)**  
**Prior Authorization of Benefits (PAB) Form**  
**Complete form in its entirety and fax to:**  
**Prior Authorization of Benefits Center at 1-844-512-9004**  
**Provider Help Desk 1-800-454-3730**

**1. PATIENT INFORMATION**
**2. PHYSICIAN INFORMATION**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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**3. MEDICATION**
**4. STRENGTH**
**5. DIRECTIONS**
**6. QUANTITY PER 30 DAYS**

Grastek (timothy grass pollen allergen extract)	_____	_____	Specify: _____
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**7. DIAGNOSIS:** \_\_\_\_\_

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Medication is prescribed in consultation with an allergist
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient has a documented intolerance to immunotherapy injections
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	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)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient is 5 through 65 years of age

**9. PHYSICIAN SIGNATURE**

_____ Prescriber or Authorized Signature	_____ Date
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Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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