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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Oralair (sweet vernal, orchard, perennial rye, timothy and kentucky blue grass mixed pollens allergenic 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: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Oralair (sweet vernal, orchard, perennial rye, timothy and kentucky blue grass mixed pollens allergenic extract)	_____	_____	Specify: _____

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.

☐ Yes	☐ No	Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis
☐ Yes	☐ No	Medication is prescribed in consultation with an allergist
☐ Yes	☐ No	Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal conrticosteroids and antihistamines)
☐ Yes	☐ No	Patient has a documented intolerance to immunotherapy injections
☐ Yes	☐ 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)
☐ Yes	☐ No	Patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT)
☐ Yes	☐ No	Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass
☐ Yes	☐ No	Patient is 10 through 65 years of age

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

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.