

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: _____ 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

Oralair (sweet vernal, orchard, perennial rye, timothy and kentucky blue grass mixed pollens allergenic 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"/>	<input type="checkbox"/>	Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis
<input type="checkbox"/>	<input type="checkbox"/>	Medication is prescribed in consultation with an allergist
<input type="checkbox"/>	<input type="checkbox"/>	Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines)
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a documented intolerance to immunotherapy injections
<input type="checkbox"/>	<input type="checkbox"/>	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"/>	<input type="checkbox"/>	Patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT)
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cockfoot, perennial rye, timothy, and Kentucky blue/June grass
<input type="checkbox"/>	<input type="checkbox"/>	Patient is 10 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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