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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

ANTI-ALLERGENS, ORAL

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Non-preferred Medications Require a SA:

- ☐ Grastek®
- ☐ Odactra®
- ☐ Oralair®
- ☐ Ragwitek™

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

1. **For Grastek®:** Does the patient have a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis?
   ☐ Yes ☐ No
2. **For Odactra®**: Does the patient have a diagnosis of house dust mite (HDM)-induced allergic rhinitis with or without conjunctivitis?
   ☐ Yes ☐ No
3. **For Oralair®:** Does the patient have a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis?
   ☐ Yes ☐ No
4. **For Ragwitek™:** Does the patient have a diagnosis of short ragweed pollen-induced allergic rhinitis with or without conjunctivitis?
   ☐ Yes ☐ No
5. Has the patient had a treatment failure with (or contraindication) to antihistamines (e.g., diphenhydramine, loratadine, etc.) and Montelukast/Singulair®?
   ☐ Yes ☐ No
   Document details: _____
   _____
6. Is there a clinical reason why the patient cannot use allergy shots?
   ☐ Yes ☐ No
   Document details: _____
   _____

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:

Prime Therapeutics Management LLC/Attn: GV – 4201

P.O. Box 64811, St. Paul, MN 55164-0811