BlueCross BlueShield Federal Employee Program

# ODACTRA
# PRIOR APPROVAL REQUEST

**Send completed form to:**
**Service Benefit Plan**
**Prior Approval**
**P.O. Box 52080 MC 139**
**Phoenix, AZ 85072-2080**
**Attn. Clinical Services**
**Fax: 1-877-378-4727**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

| **Patient Information (required)** | | | **Provider Information (required)** | | |
|---|---|---|---|---|---|
| Date: | | | Provider Name: | | |
| Patient Name: | | | Specialty: | NPI: | |
| Date of Birth: | Sex: ❑Male ❑Female | | Office Phone: | Office Fax: | |
| Street Address: | | | Office Street Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |
| Patient ID: **R** | | | Physician Signature: | | |
| **PHYSICIAN COMPLETES** | | | | | |

## Odactra

**(house dust mite allergen extract)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

**NOTE**: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 90 tablets every 90 days? ❑Yes* ❑No

***If YES***, please specify the requested quantity: _____ tablets every 90 days

1. Does the patient have a diagnosis of house dust mite (HDM)-induced allergic rhinitis? ❑Yes ❑No

2. Does the patient have severe, unstable, or uncontrolled asthma by having a significantly impaired activity level due to troublesome symptoms or using a rescue inhaler greater than two days or more per week? ❑Yes ❑No

3. Does the patient have eosinophilic esophagitis? ❑Yes ❑No

4. Will Odactra be given with other allergen immunotherapies? ❑Yes* ❑No

   ***If YES***, specify medication(s): _____

5. Has the patient been on Odactra continuously for the last **6 months** excluding samples? ❑Yes ❑No*

   ***If NO***, please answer the following questions:

   a. Does the physician have training and experience in the treatment of allergic diseases? ❑Yes ❑No

   b. Does the patient have a positive skin test or an in vitro test which confirmed pollen-specific IgE antibodies for *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites? ❑Yes ❑No

   c. Has the patient shown unacceptable response to at least one oral or intranasal steroid? ❑Yes ❑No

   d. Has the patient shown unacceptable response to at least one oral antihistamine? ❑Yes ❑No

   e. Has the patient been prescribed or given an auto-injectable epinephrine? ❑Yes* ❑No

      ***If YES***, has the patient or caregiver been instructed on the use of the auto-injectable epinephrine? ❑Yes ❑No

   f. Does the patient have a history of severe local reaction to sublingual allergen immunotherapy? ❑Yes ❑No