US Family Health Plan
Prior Authorization Request Form for
house dust mite allergen extract (Odactra)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial approval is 6 months. For renewal of therapy an initial USFHP prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Odactra*	☐ Yes (subject to verification) Proceed to question **16**	☐ No Proceed to question **2**
2. Is the requested medication being prescribed by an allergist/immunologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient between the ages of 18 and 65 years of age?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Does the patient have a diagnosis of house dust mite (HDM) allergic rhinitis?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the diagnosis been confirmed with either a positive skin test or an in vitro test for pollen-specific for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the have patient also have a diagnosis of allergic asthma?	☐ Yes Proceed to question **7**	☐ No Proceed to question **9**
7. Has the patient responded to an adequate trial of inhaled steroids?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**

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8. Is the patient's FEV1 GREATER THAN 70 percent?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
9. Has the patient's allergic rhinitis symptoms been controlled with a nasal corticosteroid (e.g., fluticasone)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Has the patient's allergic rhinitis symptoms been controlled with at least one of the following: • **oral antihistamine,** • **nasal antihistamines, or a** • **leukotriene receptor antagonist (montelukast)?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Provider is aware of boxed warning requiring monitoring of all patients for at least 30 minutes after INITIAL dose in a healthcare setting due to potential allergic reaction and agrees to administer and monitor the patient taking the first dose?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have a prescription for self-administered SC epinephrine?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient have a history of severe local allergic reaction to sublingual immunotherapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Is the patient receiving co-administered SC immunotherapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **15**
15. Does the patient have severe, uncontrolled, unstable asthma?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
16. Has the patient responded positively to treatment and is not receiving co-administered SC immunotherapy?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Does the patient have severe, uncontrolled, unstable asthma?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date