

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
Grastek Immunotherapy

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Client must be between 5 and 65 years of age
- Provide documentation of a grass pollen-induced allergic rhinitis, with or without Conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens.
- Therapy must be initiated at least 12 weeks before the expected onset of each grass pollen season. (December 5 to January 10)

AUTHORIZATION:

- One year

RE-AUTHORIZATION:

- Three consecutive years
- Client age between 5 and 65 years of age.
- Initial therapy was approved and initiated at least 12 weeks prior to expected onset of grass pollen season.
- Therapy has been continuous throughout grass pollen season.