

New Hampshire Medicaid Fee-for-Service Program Allergen Extract Criteria

Approval Date: August 7, 2020

Medications

Brand Names	Generic Names	Treatment
Grastek[®]	Timothy Grass Pollen Allergen Extract	grass-pollen-induced allergic rhinitis with or without conjunctivitis
Ragwitek[®]	Short Ragweed Pollen Allergen Extract	short-ragweed-pollen-induced allergic rhinitis with or without conjunctivitis
Oralair[®]	Grass Pollen extract	moderate to severe seasonal grass (Kentucky Blue Grass, Orchard, Perennial Rye, Sweet Vernal, and Timothy) pollen-induced allergic rhinitis with or without conjunctivitis
Odactra[®]	House Dust Mite Allergen Extract	house dust mite (HDM)-induced allergic rhinitis with or without conjunctivitis
Palforzia[™]	Peanut Allergen-dnfp	mitigation of allergic reactions, including anaphylaxis, that may occur with accidental exposure to peanut

Criteria for Approval

- Confirmed allergen by positive skin test or in vitro testing for pollen-specific IgE antibodies for approved indication (Grastek[®], Ragwitek[®], Oralair[®] and Odactra[®] only) ; **AND**
- Treatment is requested 12 weeks prior to season of allergen being treated (Grastek[®] or Ragwitek[™]) or four months prior to season of allergen being treated (Oralair[®] only).

OR

- Patient has a documented clinical history of allergy to peanuts or peanut-containing foods (Palforzia[™] only); **AND**
- Patient is on a peanut-avoidance diet and has been prescribed and/or has a refill history of epinephrine auto-injector (Palforzia[™] only).

Length of Approval: One year

Continued approval: Treatment is requested 12 weeks prior to season of allergen being treated (Grastek[®] or Ragwitek[®]) or four months prior to season of allergen being treated (Oralair[®] only)

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Dispensing Limits:

1. Grastek®/Ragwitek®/Odactra®: One per day
2. Oralair®: One per day (tablets); one dose pack total maximum limit (100 IR/300 IR dose pack)

Criteria for Denial

1. Patient is \leq five years of age (for Grastek® and Oralair® only)
2. Patient is \leq 18 years of age (for Ragwitek® and Odactra® only)
3. Patient is $<$ 4 years of age or \geq 18 years of age (Palforzia™ only)
4. Patient experienced a severe reaction post initial dose that was administered in the physician's office
5. Patient has experienced severe anaphylaxis resulting in hypotensive shock, use of $>$ 2 doses of epinephrine, and/or intubation within the prior 60 days (Palforzia™ only);
6. Request is during active season of allergen (for Grastek®, Oralair®, Ragwitek®, and Odactra® only)
 - a. Ragweed season: August–November
 - b. Grass season: June
7. Concomitant allergen immunotherapy
8. History of severe, unstable, or uncontrolled asthma
9. History of eosinophilic esophagitis
10. Patient has oral inflammation or wounds (e.g., oral lichen planus, mouth ulcers, thrush, oral surgery, dental extraction) which have not healed completely (for Odactra® only)

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	05/12/2015
Commissioner	Approval	06/30/2015
DUR Board	Revision	10/24/2017
Commissioner	Approval	12/05/2017
DUR Board	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019

Reviewed by	Reason for Review	Date Approved
DUR Board	Revision	06/30/2020
Commissioner Designee	Approval	08/07/2020