



# New Hampshire Medicaid Fee-for-Service (FFS) Program

## Prior Authorization Drug Approval Form

Allergen Extract Medications

DATE OF MEDICATION REQUEST:    /    /

### SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH:

GENDER:  Male  Female

Drug Name

Strength

Dosing Directions

Length of Therapy

### SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER:

FAX NUMBER:

### SECTION III: CLINICAL HISTORY

- For what condition is this medication being prescribed? \_\_\_\_\_
- Was allergen confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for approved indication?  Yes  No
- Palforzia<sup>TM</sup> only*: Does the patient have a documented clinical history of allergy to peanuts or peanut-containing foods?  Yes  No
- Palforzia<sup>TM</sup> only* Is the patient on a peanut-avoidance diet and has been prescribed and/or has a refill history of epinephrine auto-injector?  Yes  No
- Did the patient experience a severe reaction post-initial dose administration of medication requested?  Yes  No
- Will the patient be on concomitant allergen immunotherapy?  Yes  No
- Palforzia<sup>TM</sup> only*: Has the patient experienced severe anaphylaxis resulting in hypotensive shock, used > 2 doses of epinephrine, and/or had intubation within the prior 60 days?  Yes  No

(Form continued on next page.)



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**DATE OF MEDICATION REQUEST:**    /    /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**SECTION III: CLINICAL HISTORY (CONTINUED)**

8. Does the patient have a history of severe, unstable, or uncontrolled asthma?  Yes  No
9. Does the patient have a history of eosinophilic esophagitis?  Yes  No
10. *Odaetra™ only*: Does the patient have any oral inflammation or wounds (e.g., oral lichen planus, mouth ulcers, thrush, oral surgery, dental extraction) that have not healed completely?  Yes  No

Provide any additional information that would help in the decision-making process. *If additional space is needed, please use a separate sheet.*

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_