AmeriHealth Caritas™
New Hampshire

Allergen Extract Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / ______

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information	
Prescriber last name:	Prescriber first name:
Prescriber address:	Prescriber representative:
NPI number:	Specialty:
Phone #:	Fax #:

Clinical history
1. For what condition is this medication being prescribed?
2. Was allergen confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for approved indication? ☐ Yes ☐ No
3. Did patient experience a severe reaction post initial dose administration of medication requested? ☐ Yes ☐ No
4. Will the patient be on concomitant allergen immunotherapy? ☐ Yes ☐ No
5. Does the patient have a history of severe, unstable, or uncontrolled asthma? ☐ Yes ☐ No
6. Does the patient have a history of eosinophilic esophagitis? ☐ Yes ☐ No
7. For Odactra™ 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.

Signature of prescriber:______________________________ Date: ______________
(prescriber signature mandatory)

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.