Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Sublingual Allergen Immunotherapy

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard
☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)* ICD10:

☐ Grastek sublingual tablet
☐ Odactra sublingual tablet
☐ Oralair sublingual tablet
☐ Ragwitek sublingual tablet
☐ other (please specify):

Directions for use: Dose & Quantity: Duration of therapy:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

What is your patient's diagnosis?
☐ grass pollen-induced allergic rhinitis
☐ short ragweed pollen-induced allergic rhinitis
☐ house dust mite-induced allergic rhinitis
☐ other *(please specify):*

Clinical Information:
Does the patient have documented failure or inadequate response, contraindication per FDA label, intolerance, or is not a candidate for intranasal corticosteroid therapy? Yes ☐ No ☐

Does the patient have documented failure or inadequate response, contraindication per FDA label, intolerance, or is not a candidate for EITHER oral antihistamines OR intranasal antihistamines? Yes ☐ No ☐

While taking the requested drug, will your patient also use any other sublingual allergen immunotherapy agents (for example, Grastek, Odactra, Oralair, Ragwitek) during the same time period?
☐ Yes or Possibly
☐ No
☐ Unknown

(If requesting Grastek)

Has the patient's diagnosis been confirmed by a positive in vitro test (i.e., a blood test) for allergen-specific immunoglobulin E(IgE) antibodies for a grass in the Pooideae subfamily of grasses? Yes ☐ No ☐

Has the patient's diagnosis been confirmed by a positive skin test response to a grass pollen from the Pooideae subfamily of grasses? Yes ☐ No ☐

Is this a new start or continuation of therapy? ☐ new start of therapy ☐ continued therapy

(if new start) Treatment must be initiated at least 12 weeks before the onset of grass pollen season. Will the patient begin therapy between September through the end of January? Yes ☐ No ☐

(If requesting Odactra)

Has the patient's diagnosis been confirmed by a positive in vitro test (i.e., a blood test for allergen-specific IgE antibodies) for house dust mite (HDM)? Yes ☐ No ☐

Has the patient's diagnosis been confirmed by a positive skin test response to house dust mite allergen extracts? Yes ☐ No ☐

(If requesting Oralair)

Has the patient's diagnosis been confirmed by a positive in vitro test (i.e., a blood test) for allergen-specific immunoglobulin E (IgE) antibodies for a grass in the Pooideae subfamily of grasses? Yes ☐ No ☐

Has the patient's diagnosis been confirmed by a positive skin test response to a grass pollen from the Pooideae subfamily of grasses? Yes ☐ No ☐

Is this a new start or continuation of therapy? ☐ new start of therapy ☐ continued therapy

(if new start) Treatment must be initiated 4 months before the onset of grass pollen season. Will the patient begin therapy between September through the end of December? Yes ☐ No ☐

(If requesting Ragwitek)

Has the patient's diagnosis been confirmed by a positive in vitro test (i.e., a blood test) for allergen-specific immunoglobulin E (IgE) antibodies for short ragweed pollen? Yes ☐ No ☐

Has the patient's diagnosis been confirmed by a positive skin test response to short ragweed pollen? Yes ☐ No ☐

Is this a new start or continuation of therapy? ☐ new start of therapy ☐ continued therapy

(if new start) Treatment must be initiated at least 12 weeks before the onset of ragweed pollen season. Will the patient begin therapy between November through the end of April? Yes ☐ No ☐

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:____ **Date:**____________________

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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