New Hampshire AIDS Drug Assistance 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

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

(Form continues on the next page.)

Phone: 1-800-424-7901
Fax: 1-800-424-7984

Review date: 08/13/2021

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PATIENT LAST NAME:

PATIENT FIRST NAME:

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

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**: _____

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Magellan Rx MANAGEMENT