AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM ANTI-ALLERGENS, ORAL

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

PATIENT INFORMATION														
Last Name:	First Name:													
Medicaid ID Number:	Date of Birth:													
Gender: Male Female	Weight in Kilograms:													
PRESCRIBER INFORMATION														
Last Name:	First Name:													
NPI Number:														
Phone Number:	Fax Number:													
DRUG INFORMATION														
Non-preferred Medications Require a PA:														
☐ Grastek®														
Odactra®														
Oralair®														
Ragwitek™														
Drug Name/Form:														
Strength:														
Dosing Frequency:														
Length of Therapy:														
Quantity per Day:														
(Form continued on next page.)														

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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM: Anti-Allergens, Oral

Patient's Last Name:													Patient's First Name:										
DI	DIAGNOSIS AND MEDICAL INFORMATION																						
1.	For Grastek®: Does the patient have a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis? Yes No															t							
2.	For Odactra ®: Does the patient have a diagnosis of house dust mite (HDM)-induced allergic rhinitis with or without conjunctivitis?													or									
3.	 Yes																						
4.														h or									
5.	 Has the patient had a treatment failure with (or contraindication) to antihistamines (e.g., diphenhydramine loratadine, etc.) and Montelukast/Singulair®? Yes No Document details: 												ne,										
6.	6. Is there a clinical reason why the patient cannot use allergy shots? Yes No Document details:																						
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Ву	_	ture	, the	Physi	cian	-	rms th	ne ab	ove	infor	·ma	ation	is ac	curat	te		Da	ite					

Please include ALL requested information; Incomplete forms will delay the PA process. Submission of documentation does NOT guarantee coverage.

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