

Criteria for Indiana Medicaid Allergy-Specific Immunotherapy

Prepared for State of Indiana by OptumRx

EXECUTIVE SUMMARY

Purpose: Promote prudent prescribing of allergy-specific oral immunotherapy agents

Setting & Population: All members

Type of Criteria: Increased Risk of ADE Non-Preferred Agent
 Appropriate Indications Other:

Data Sources: Only administrative databases Databases + Prescriber-supplied

TARGETED PRODUCTS

Drug Name
GRASTEK (TIMOTHY GRASS POLLEN ALLERGEN EXTRACT)
ODACTRA (DUST MITE ALLERGEN EXTRACT)
ORALAIR (SWEET VERNAL, ORCHARD, PERENNIAL RYE, TIMOTHY AND KENTUCKY BLUE GRASSES MIXED POLLENS ALLERGEN EXTRACT)
PALFORZIA (PEANUT ALLERGEN POWDER)
RAGWITEK (SHORT RAGWEED POLLEN ALLERGEN EXTRACT)

APPROVAL DURATION

- Approvals will be granted for up to 1 year

APPROVAL CRITERIA

Prior authorization for the prescribed drug will be granted when the following approval criteria has been met:

GRASTEK (TIMOTHY GRASS POLLEN ALLERGEN EXTRACT)

Initial Authorization

- Must meet all of the following:
 - Diagnosis of grass-pollen induced allergic rhinitis
 - Documentation of a positive skin test or in vitro test for Timothy Grass or cross-reactive grass pollens
 - Member must be between 5 and 65 years of age
 - Prescribed by, or in consultation with, an allergist or immunologist
 - One of the following:
 - Previous trial and failure (inadequate response) to ≥ 90 days of drug therapy with EACH of the following: intranasal corticosteroid, leukotriene inhibitor, antihistamine agent
 - Prescriber has provided documentation of contraindication to or intolerance of intranasal corticosteroids, leukotriene inhibitors, and/or antihistamine agents
 - One of the following:
 - Previous trial and failure of injectable immunotherapy (allergy shots)
 - Prescriber has provided documentation of contraindication to injectable immunotherapy

Criteria for Indiana Medicaid Allergy-Specific Immunotherapy

- Requested dose does not exceed 1 tablet (2,800 BAU) daily
- None of the following contraindications:
 - Severe, unstable or uncontrolled asthma
 - Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

Reauthorization

- Must meet the following:
 - History of the requested agent within the past 90 days

ODACTRA (DUST MITE ALLERGEN EXTRACT)

Initial Authorization

- Must meet all of the following:
 - Diagnosis of house dust mite-induced allergic rhinitis
 - Documentation of a positive skin test or in vitro test for IgE antibodies to house dust mites (*Dermatophagoides farinae* or *Dermatophagoides pteronyssinus*)
 - Member must be between 5 and 65 years of age
 - Prescribed by, or in consultation with, an allergist or immunologist
 - One of the following:
 - Previous trial and failure (inadequate response) to ≥ 90 days of drug therapy with EACH of the following: intranasal corticosteroid, leukotriene inhibitor, antihistamine agent
 - Prescriber has provided documentation of contraindication to or intolerance of intranasal corticosteroids, leukotriene inhibitors, and/or antihistamine agents
 - One of the following:
 - Previous trial and failure of injectable immunotherapy (allergy shots)
 - Prescriber has provided documentation of contraindication to injectable immunotherapy
 - Requested dose does not exceed 1 tablet (12 SQ-HDM) daily
 - None of the following contraindications:
 - Severe, unstable or uncontrolled asthma
 - Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

Reauthorization

- Must meet the following:
 - History of the requested agent within the past 90 days

ORALAIR (SWEET VERNAL, ORCHARD, PERENNIAL RYE, TIMOTHY AND KENTUCKY BLUE GRASSES MIXED POLLENS ALLERGEN EXTRACT)

Initial Authorization

- Must meet all of the following:
 - Diagnosis of grass pollen-induced allergic rhinitis
 - Documentation of a positive skin test or in vitro test for any of the five grass species: Sweet Vernal, Orchard, Perennial Rye, Timothy or Kentucky Blue Grass
 - Member must be between 5 and 65 years of age
 - Prescribed by, or in consultation with, an allergist or immunologist
 - One of the following:
 - Previous trial and failure (inadequate response) to ≥ 90 days of drug therapy with EACH of the following: intranasal corticosteroid, leukotriene inhibitor, antihistamine agent
 - Prescriber has provided documentation of contraindication to or intolerance of intranasal corticosteroids, leukotriene inhibitors, and/or antihistamine agents
 - One of the following:
 - Previous trial and failure of injectable immunotherapy (allergy shots)
 - Prescriber has provided documentation of contraindication to injectable immunotherapy

Criteria for Indiana Medicaid Allergy-Specific Immunotherapy

- Requested dose does not exceed the following:
 - 3 X 100mg tablets maximum per month for induction therapy in members ages 5 to 17 years
 - 1 tablet (300mg) daily
- None of the following contraindications:
 - Severe, unstable or uncontrolled asthma
 - Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

Reauthorization

- Must meet the following:
 - History of the requested agent within the past 90 days

PALFORZIA (PEANUT ALLERGEN POWDER)

Initial Authorization

- Must meet all of the following:
 - Diagnosis of peanut allergy
 - Member must be between 1 and 17 years of age
 - Prescribed by, or in consultation with, an allergist or immunologist
 - None of the following contraindications:
 - Severe, unstable or uncontrolled asthma
 - Severe or life-threatening anaphylaxis reaction in the past 60 days
 - History of eosinophilic esophagitis or other eosinophilic GI disease

Reauthorization

- Must meet both of the following:
 - History of the requested agent within the past 90 days
 - Requested dose does not exceed 300mg daily
- Note: starter pack will be limited to 1 pack every 90 days**

RAGWITEK (SHORT RAGWEED POLLEN ALLERGEN EXTRACT)

Initial Authorization

- Must meet all of the following:
 - Diagnosis of short ragweed pollen-induced allergic rhinitis
 - Documentation of a positive skin test or in vitro test for short ragweed pollen
 - Member must be between 5 and 65 years of age
 - Prescribed by, or in consultation with, an allergist or immunologist
 - One of the following:
 - Previous trial and failure (inadequate response) to ≥ 90 days of drug therapy with EACH of the following: intranasal corticosteroid, leukotriene inhibitor, antihistamine agent
 - Prescriber has provided documentation of contraindication to or intolerance of intranasal corticosteroids, leukotriene inhibitors, and/or antihistamine agents
 - One of the following:
 - Previous trial and failure of injectable immunotherapy (allergy shots)
 - Prescriber has provided documentation of contraindication to injectable immunotherapy
 - Requested dose does not exceed 1 tablet (12 Amb a 1-U) daily
 - None of the following contraindications:
 - Severe, unstable or uncontrolled asthma
 - Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

Reauthorization

- Must meet the following:
 - History of the requested agent within the past 90 days

**Criteria for Indiana Medicaid
Allergy-Specific Immunotherapy**

- Existing Criteria
- Revision of Existing Criteria
- New Criteria