**Oral Immunotherapy Agents Prior Authorization Program Summary with Quantity Limit**

This program applies to FlexRx Open, GenRx Open, Health Insurance Marketplace, FocusRx and KeyRx formularies.

This is a FlexRx Standard and GenRx Standard prior authorization program.

The BCBS MN Step Therapy Supplement also applies to this program for all Commercial/HIM lines of business.

Program specific denial language for prerequisite step therapy component does not apply. Instead, supplemental program denial language will apply.

**FDA LABELED INDICATIONS**

<table>
<thead>
<tr>
<th>Product</th>
<th>Indication(s)</th>
<th>Dosage and Administration*</th>
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</thead>
<tbody>
<tr>
<td><strong>Grastek®</strong>&lt;sup&gt;1-3,10&lt;/sup&gt; (Timothy Grass Pollen Allergen Extract)</td>
<td>Treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens. Grastek is approved for use in persons 5 through 65 years of age.</td>
<td>Take one tablet daily; place tablet under the tongue and allow it to remain there until completely dissolved. Do not take with food. Initiate treatment at least 12 weeks before the expected onset of each grass pollen season and continue throughout the season. For sustained effectiveness Grastek may be taken daily for 3 consecutive years (including intervals between grass pollen seasons). Administer the first dose under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases. Observe patients in the office for at least 30 minutes following the initial dose.</td>
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<tr>
<td><strong>Odactra™</strong>&lt;sup&gt;1-3,10&lt;/sup&gt; (House Dust Mite: Dermatophagoides farinae and Dermatophagoides pteronyssinus Allergen Extract)</td>
<td>Immunotherapy for house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, confirmed by in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, or skin testing to licensed house dust mite allergen extracts. Odactra is approved for use in adults 18 through 65 years of age.</td>
<td>Take one tablet daily; place tablet under the tongue where it will dissolve within 10 seconds. Do not swallow for at least 1 minute. Do not take with food or beverage. Administer the first dose under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases. Observe the patient for at least 30 minutes following the initial dose.</td>
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<tr>
<td><strong>Oralair®</strong>&lt;sup&gt;1,3,10&lt;/sup&gt; (Sweet Vernal, Orchard, Perennial Rye, Timothy, Treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis</td>
<td>Adults (age 18-65) Take one tablet (300 IR) daily</td>
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| **and Kentucky Blue grass Mixed Pollens Allergen extract)** | **confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product. Oralair is approved for use in persons 10 through 65 years of age.** | **Children, Adolescents (age 10-17)**
Increase dose over the first few days:
Day 1 – 100 IR
Day 2 – 100 IR x 2
Day 3 and following – 300 IR
Place tablet under the tongue and allow it to remain there until completely dissolved. Do not take with food. Administer Oralair to children under adult supervision.
Initiate treatment at least 4 months before the expected onset of each grass pollen season and continue throughout the season.
Administer the first dose under the supervision of a physician with experience in the diagnosis and treatment of severe allergic reactions. Observe the patient for at least 30 minutes. |
|---|---|---|
| **Sublingual tablet – 100 IR 300 IR (Index of Reactivity)** | **Ragwitek® (Short Ragweed Pollen Allergen Extract)**
Sublingual tablet – 12 Amb a 1-Unit | **Treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen. Ragwitek is approved for use in adults 18 through 65 years of age.**
Take one tablet daily; place tablet under the tongue and allow it to remain there until completely dissolved. Do not take with food.
Initiate treatment at least 12 weeks before the expected onset of ragweed pollen season and continue throughout the season.
Administer the first dose in a healthcare setting under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases. After receiving the first dose, observe the patient for at least 30 minutes to monitor for signs or symptoms of a severe systemic or a severe local allergic reaction. If the patient tolerates the first dose, the patient may take subsequent doses at home. **

* Administer the first dose of these products in a healthcare setting under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases. After receiving the first dose of the product, observe the patient for at least 30 minutes to monitor for signs or symptoms of a severe systemic or a severe local allergic reaction. If the patient tolerates the first dose, the patient may take subsequent doses at home.**

**CLINICAL RATIONALE Guidelines**
Conventional pharmacotherapy for allergic rhinitis include antihistamines, nasal corticosteroids, oral corticosteroids, and leukotriene inhibitors. Intranasal corticosteroids are considered the most effective conventional pharmacotherapy.4

Guidelines consider both sublingual immunotherapy (SLIT) and subcutaneous immunotherapy (SCIT) effective treatments for adults and children with rhinosinusitis that does not respond to conventional pharmacotherapy and allergen avoidance measures.

Immunotherapy may be considered in asthma patients with a clear relationship of asthma symptoms with allergens such as asthma with allergic rhinoconjunctivitis, however there is no clear or consistent evidence that lung function improves.5-9

**Safety**1-3,10
All four oral immunotherapy agents carry the same boxed warning:

- Can cause life-threatening allergic reactions such as anaphylaxis and severe laryngopharyngeal edema/restriction.
- Do not administer to patients with severe, unstable or uncontrolled asthma.
- Observe patients in the office for at least 30 minutes following the initial dose.
- Prescribe auto-injectable epinephrine, instruct and train patients on its appropriate use, and instruct patients to seek immediate medical care upon its use.
- May not be suitable for patients with certain underlying medical conditions that may reduce their ability to survive a serious allergic reaction.
- May not be suitable for patients who may be unresponsive to epinephrine or inhaled bronchodilators, such as those taking beta-blockers.

All four oral immunotherapy agents carry the same contraindications:

- Severe, unstable or uncontrolled asthma.
- History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy.
- A history of eosinophilic esophagitis.
- Hypersensitivity to any of the inactive ingredients contained in this product.

Grastek, Odactra, Oralair, and Ragwitek have not been studied in subjects who are receiving concomitant allergen immunotherapy. Concomitant dosing with other allergen immunotherapy may increase the likelihood of local or systemic adverse reactions to either subcutaneous or sublingual allergen immunotherapy.1,2,3,10

For additional clinical information see Prime Therapeutics Formulary Chapter 6.3E: Allergenic Extracts.

**References:**
Oral Immunotherapy Agents Prior Authorization with Quantity Limit

OBJECTIVE
The intent of the Oral Immunotherapy Agents Prior Authorization (PA) program is to ensure appropriate selection of patients for treatment according to product labeling and guidelines. The PA defines appropriate use based on FDA approved package information and current clinical guidelines published by the Joint Task Force on Practice Parameters for Allergy and Immunology. The PA defines appropriate use as immunotherapy of allergic rhinitis in patients who have a positive skin test or IgE specific antibodies who have tried at least two traditional allergy medications, one of which is a nasal corticosteroid or have a documented intolerance, FDA labeled contraindication, or hypersensitivity to traditional treatments. PA criteria also include documentation of provider’s specialty (allergy or immunology), documentation that the patient is to receive the first dose under direct supervision (30 minutes) of that provider and that the patient has epinephrine injection available at home, and initiation of therapy at the required interval before the pollen season. Appropriate dosing based on FDA labeling will be included with a quantity limit of one tablet per day. Requests for oral immunotherapy agents will be reviewed when patient-specific documentation has been provided.

TARGET AGENTS
- **Grastek®** (Timothy Grass Pollen Allergen Extract)
- **Odactra™** (Dermatophagoides farinae and Dermatophagoides pteronyssinus Allergen Extract)
- **Oralair®** (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen extract)
- **Ragwitek®** (Short Ragweed Pollen Allergen Extract)

QUANTITY LIMITS FOR TARGET AGENTS

<table>
<thead>
<tr>
<th>Brand (generic)</th>
<th>GPI</th>
<th>Multisource Code</th>
<th>Quantity Limit</th>
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<tbody>
<tr>
<td><strong>Grastek</strong> (Timothy Grass Pollen Allergen Extract)</td>
<td>20100048000740</td>
<td>M, N, O, or Y</td>
<td>1 tablet/day</td>
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<tr>
<td>Tablet, 2800 BAUs (Bioequivalent Allergy Units)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Odactra</strong> (Dermatophagoides farinae and Dermatophagoides pteronyssinus Allergen Extract)</td>
<td>20109902220740</td>
<td>M, N, O, or Y</td>
<td>1 tablet/day</td>
</tr>
<tr>
<td>Tablet, 12 SQ-HDM biological potency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oralair</strong> (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen extract)</td>
<td>20109905200730</td>
<td>M, N, O, or Y</td>
<td>1 tablet/day</td>
</tr>
<tr>
<td>Tablet, 300 IR (index of reactivity)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children/Adolescent Starter Pack</td>
<td>20109905200720</td>
<td>M, N, O, or Y</td>
<td>1 pack/180 days</td>
</tr>
<tr>
<td><strong>Ragwitek</strong> (Short Ragweed Pollen Allergen Extract)</td>
<td>20100060200720</td>
<td>M, N, O, or Y</td>
<td>1 tablet/day</td>
</tr>
<tr>
<td>Tablet, 12 Amb a 1-U (Amb a 1-Unit)</td>
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</table>

PRIOR AUTHORIZATION CRITERIA FOR APPROVAL
**Grastek, Odactra, Oralair, or Ragwitek** will be approved when ALL of the following are met:

1. The patient has a diagnosis of allergic rhinitis, with or without conjunctivitis

AND

2. The patient’s diagnosis is confirmed with ONE of the following:
   a. Positive skin test to ONE of the pollen extracts included in the requested agent (Grastek, Oralair, or Ragwitek) or licensed house dust mite allergen (Odactra)

OR
b. IgE specific antibodies to ONE of the extracts included in the requested agent:
   i. Grastek: Timothy grass or cross-reactive grass
   ii. Odactra: Dermatophagoides farinae or Dermatophagoides pteronyssinus
   iii. Oralair: Sweet vernal, orchard, perennial rye, Timothy, or Kentucky blue grass
   iv. Ragwitek: Short Ragweed

AND

3. The patient is within the FDA labeled age range:
   a. Grastek: between the ages of 5 and 65
   b. Odactra: between the ages of 18 and 65
   c. Oralair: between the ages of 10 and 65
   d. Ragwitek: between the ages of 18 and 65

AND

4. The prescriber is an allergy or immunology specialist or has consulted an allergy or immunology specialist

AND

5. ONE of the following:
   a. The patient has tried and failed at least two traditional allergy medications, one of which was an intranasal corticosteroid
   OR
   b. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least two standard allergy therapies, one of which was an intranasal corticosteroid

AND

6. The patient is not currently using subcutaneous injectable immunotherapy

AND

7. IF the requested agent is Grastek, Oralair, or Ragwitek: The product will be started, or has already been started, 3 to 4 months before the expected onset of the applicable pollen season

AND

8. The first dose is given in the clinic/hospital under direct supervision from the provider for a period of at least 30 minutes

AND

9. The patient has been prescribed epinephrine auto-injector for at home emergency use

AND

10. The patient does not have any FDA labeled contraindications to the requested agent

AND

11. ONE of the following:
   a. The requested quantity (dose) is less than or equal to the program quantity limit
   OR
   b. ALL of the following:
      i. The requested quantity (dose) is above the set limit
      AND
      ii. ONE of the following:
         1. BOTH of the following
            a. The requested quantity (dose) requested is below the FDA labeled dose
            AND
            b. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the limit
         OR
         2. BOTH of the following:
            a. The requested quantity (dose) requested is above the FDA labeled dose

OR
**AND**

b. The prescriber has submitted documentation in support of therapy with a higher dose for the intended diagnosis which has been reviewed and approved by the Clinical Review pharmacist

**Length of approval:** 12 months
Step Therapy Supplement

This program applies to FlexRx Closed, FlexRx Open, GenRx Closed, GenRx Open, Health Insurance Marketplace, FocusRx and KeyRx formularies.

Please note, this does not include or apply to quantity limit questions.

STEP THERAPY SUPPLEMENT

OBJECTIVE

The intent of the Step Therapy Supplement is to provide additional questions, to ensure compliance to MN Statute 62Q.184. These questions will apply if the step therapy component within a Prior Authorization or Step Therapy program is not able to be approved.

CONDITIONS FOR APPROVAL

The requested agent will be approved when ONE of the following are met:

1. The patient is currently being treated with the requested agent as indicated by ALL of the following:
   a. A statement by the prescriber that the patient is currently taking the requested agent
   AND
   b. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent
   AND
   c. The prescriber states that a change in therapy is expected to be ineffective or cause harm

   OR

2. The patient’s medication history include the required prerequisite/preferred agent(s) as indicated by:
   a. Evidence of a paid claim(s) within the past 999 days
   OR
   b. The prescriber has stated that the patient has tried the required prerequisite/preferred agent(s) in the past 999 days AND the required prerequisite/preferred agent(s) was discontinued due to lack of effectiveness or an adverse event

   OR

3. The prescriber has provided documentation that the required prerequisite/preferred agent(s) cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm

Length of Approval: As per program specific criteria