Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

Oralair™ (mixed pollens allergen extract)

**Review Criteria**
Member must meet all the following criteria:

- **Initial Approval:**
  - Requires allergist consult to confirm specific allergy (by positive skin-prick test or pollen specific IgE test to specific grass pollen allergens). **This can be written or verbal confirmation from the allergist.**
  - Requires trial on an oral antihistamine AND nasal steroid which both have been ineffective, contraindicated or not tolerated
  - **Approval duration** is determined on whether patient is taking seasonally or year-round
    - Limitations:
      - MDD 1.0

- **Annual Renewal:**
  - Determine compliance via fill history. If not compliant, initiate discussion with provider to determine appropriateness of continuation of therapy
  - If approved, approval duration above applies