

Clinical Policy Title:	short ragweed pollen allergen extract
Policy Number:	RxA.272
Drug(s) Applied:	Ragwitek®
Original Policy Date:	02/07/2020
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Allergic Rhinitis (must meet all):

1. Diagnosis of short ragweed pollen-induced allergic rhinitis;
2. Confirmation of a positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen;
3. Trial and failure of at least one (1) intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
4. Trial and failure of at least one (1) one oral antihistamine, unless contraindicated or clinically significant adverse effects are experienced.

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Allergic Rhinitis (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. Wallace DV, Dykewicz MS, Bernstein DI, Blessing-Moore J, Cox L, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph CC, Schuller D, Spector SL, Tilles SA, Joint Task Force on Practice, American Academy of Allergy, Asthma & Immunology, American College of Allergy, Asthma and Immunology, Joint Council of Allergy, Asthma and Immunology. The diagnosis and management of rhinitis: an updated practice parameter. J Allergy Clin Immunol. 2008;122(2 Suppl):S1-84. Available at: <https://pubmed.ncbi.nlm.nih.gov/18662584>. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established	01/2020	02/07/2020
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Drug(s) Applied was updated.	07/03/2020	09/14/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<ul style="list-style-type: none"> 3. Line of Business Policy Applies to was updated. 4. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..." 5. Commercial approval duration and Medicaid approval duration updated. 6. References were updated. 		
<p>Policy was reviewed:</p> <ul style="list-style-type: none"> 1. Last Review Date was updated. 2. References were updated. 	02/24/2021	06/10/2021
<p>Policy was reviewed:</p> <ul style="list-style-type: none"> 1. Initial Approval Criteria, I.A.3: Updated age criteria from Age ≥ 18 years and ≤ 65 years; to Age ≥ 5 years and ≤ 65 years; 2. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance..." 3. References were reviewed and updated. 	01/24/2022	04/18/2022
<p>Policy was reviewed:</p> <ul style="list-style-type: none"> 1. References were reviewed and updated. 	01/02/2023	04/13/2023
<p>Policy was reviewed.</p>	10/19/2023	10/19/2023
<p>Policy was reviewed:</p> <ul style="list-style-type: none"> 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 5. Removed reauthorization requirement for positive response to therapy. 6. Updated approval duration verbiage. 7. References were reviewed and updated. 	8/28/2024	9/13/2024
<p>Policy was reviewed.</p>	12/05/2024	N/A
<p>Policy reviewed</p>	12/11/2025	12/11/2025