



Request for Prior Authorization
OMALIZUMAB- (XOLAIR®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for Xolair®. Payment for Xolair® will be authorized when the following criteria are met: Moderate to Severe Persistent Asthma: 1) Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and 2) Patient is 12 years of age or older; and 3) Pretreatment IgE level is between 30 IU/mL and 700 IU/mL; and 4) Patient's weight is between 30 kg and 150 kg; and 5) History of positive skin or RAST test to a perennial aeroallergen; and 6) Prescriber is an allergist, immunologist or pulmonologist; and 7) Patient is currently using a high dose inhaled corticosteroid AND long-acting beta-agonist, is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy. 8) Patient has access to an EpiPen to treat allergic reactions that may occur after administration of Xolair®. If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to Xolair® therapy and for patients who do not continue concurrent use with a high dose inhaled corticosteroid and long-acting beta-agonist. Chronic Idiopathic Urticaria: 1) Patient has a diagnosis of moderate to severe chronic urticaria; and 2) Patient is 12 years of age or older; and 3) Patient has documentation of a trial and therapy failure with at least one second-generation antihistamine, one of which must be cetirizine at a dose up to 20mg per day; and 4) Patient has documentation of a trial and therapy failure with at least one first-generation antihistamine; and 5) Patient has documentation of a trial and therapy failure with at least one potent H1 receptor antagonist (hydroxyzine and/or doxepin); and 6) Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first-or second- generation antihistamine. If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

Xolair [checkbox]

Strength Dosage Instructions Quantity Days Supply

Diagnosis: _____

Moderate to Severe Persistent Asthma: [checkbox] Mild [checkbox] Moderate [checkbox] Severe

Inhaled Corticosteroid trial: Drug Name: _____ Strength: _____ Instructions: _____

Trial date from: _____ Trial date to: _____

Inhaled Long-Acting Beta-Agonist trial: Drug Name: _____ Strength: _____ Instructions: _____

Trial date from: _____ Trial date to: _____

Medical or contraindication reason to override trial requirements: _____

Pretreatment IgE level: _____ Date Obtained: _____

Patient's Weight (kg): _____ Date Obtained: _____

History of positive skin or RAST test to a perennial aeroallergen: [checkbox] Yes [checkbox] No Date Performed: _____

Please state prescriber's specialty: _____

Patient has access to EpiPen: [checkbox] Yes [checkbox] No

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For Renewals Only: Has patient shown adequate response to Xolair® therapy? Yes No

Please describe: _____

Chronic Idiopathic Urticaria: Mild Moderate Severe

Second-Generation Antihistamine trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

First-Generation Antihistamine trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

Potent H1 receptor antagonist trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

Preferred Leukotriene Receptor Antagonist in combination with a first-or second- generation antihistamine:

Leukotriene Receptor Antagonist trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

First-or Second-Generation Antihistamine trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

For Renewals Only: Has patient shown adequate response to Xolair® therapy? Yes No

Please describe: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*