

Request for Prior Authorization
OMALIZUMAB (XOLAIR)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Online
covermymeds.com/main/prior-authorization-forms/

3. Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and
4. Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and
5. 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. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy.

Nasal Polyps:

1. Patient has a diagnosis of nasal polyps; and
2. Pretreatment IgE level is within the following range:
 - a. Adults and adolescent patients 12 years of age or older- 30 IU/mL to 1500 IU/mL; and
3. Patient's weight is within the following range:
 - a. Adults and adolescent patients 12 years of age or older- 30 kg to 150 kg; and
4. Patient has documentation of an adequate trial and inadequate response with at least two nasal corticosteroids at a maximally tolerated dose; and
5. Will be used concomitantly with a nasal corticosteroid; and
6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.

If criteria for coverage are met, the initial authorization will be given for 24 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 omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

Xolair prefilled syringe

Strength	Dosage Instructions	Quantity	Days Supply
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Diagnosis: _____

Was therapy initiated in a healthcare setting, under the guidance of a healthcare provider for a minimum of 3 doses?

Yes Date dose 1: _____ Date dose 2: _____ Date dose 3: _____ No

Has healthcare provider determined self-administration is appropriate based on careful assessment of risk for anaphylaxis and mitigation strategies, as outlined in the label? Yes No

Prescriber Specialty: Allergist Dermatologist Immunologist Otolaryngologist Pulmonologist
Other (specify): _____

Patient has access to epinephrine injection: Yes No

Has patient been educated on proper storage and administration? Yes No

Moderate to Severe Persistent Asthma:

Date of diagnosis: _____

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

Trial dates: _____

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

Trial dates: _____

Leukotriene Receptor Antagonist trial: Drug Name: _____ Strength: _____ Instructions: _____

Trial dates: _____

Medical or contraindication reason to override trial requirements: _____

Pretreatment IgE level: _____ Date Obtained: _____

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

Is Xolair being dosed according to manufacturer labeling based on pretreatment serum IgE and body weight:

Yes No

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

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

Please describe: _____

Moderate to Severe Chronic Idiopathic Urticaria:

Preferred Second-Generation Antihistamine trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Preferred First-Generation Antihistamine trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Preferred Potent H1 receptor antagonist trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

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

Preferred Leukotriene Receptor Antagonist trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Preferred First-or Second-Generation Antihistamine trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

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

Please describe: _____

Nasal Polyps:

Pretreatment IgE level: _____ Date Obtained: _____

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

Nasal Corticosteroid Trials:

Trial 1: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Trial 2: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Will omalizumab be used concurrently with a nasal corticosteroid? Yes Drug Name: _____ No

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Is Xolair being dosed according to manufacturer labeling based on pretreatment serum IgE and body weight:
Yes No

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

Please describe: _____

Is patient currently using a nasal corticosteroid? Yes No

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.