XOLAIR (OMALIZUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 7/30/20)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:	
State license #:	NPI:	MA Provider ID #	
Street address:	Suite #:	City/state/zip:	
Phone:	Fax:		

CLINICAL INFORMATION

Medication requested: ☐ Xolair 150 mg/ml syringe ☐ Xolair 150 mg vial ☐ Xolair 75 mg/0.5 ml syringe ☐ Xolair _____

Dose/directions:	Quantity:	Duration: months
Diagnosis:	Dx code *(required)*:	Weight: lbs / kg

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication, if applicable):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) INFORMATION (if applicable):

Treatment setting: ☐ Infusion Center ☐ Home ☐ Provider's Office ☐ Hospital Outpatient Facility		
Facility name:	Facility NPI:	
J-code:	Number of units:	Date of service (MM/DD/YYYY):

INITIAL REQUESTS

1. Is Xolair being prescribed by or in consultation with a specialist? ☐ Yes – *Provide specialty:*_____ ☐ No
2. <u>For a diagnosis of asthma</u>: Is the patient being treated for moderate to severe persistent asthma induced by an unavoidable perennial allergen (pollen, mold, dust mites, etc.) and inadequately controlled by inhaled corticosteroids? ☐ Yes – *Submit documentation, including results of allergen reactivity test.* ☐ No
3. <u>For a diagnosis of asthma</u>: Does the patient have a serum total IgE measurement between 30 international units (IU)/ml and 1300 IU/ml? ☐ Yes ☐ No
   IgE level:_____ Date of result:_____
4. <u>For a diagnosis of asthma:</u> Is the patient currently receiving optimally titrated doses, or have a contraindication or intolerance to, any of the following?
   ☐ inhaled glucocorticoid ☐ leukotriene modifier ☐ long-acting beta-agonist (LABA) ☐ other (e.g., tiotropium, theophylline): _____
   ☐ Yes – List medications being used: _____
   ☐ No
5. <u>For a diagnosis of chronic idiopathic urticaria (CIU):</u> Does the patient have a history of urticaria for a period of ≥ 3 months? ☐ Yes – *Submit documentation.* ☐ No
6. For a diagnosis of CIU: Does the patient require the use of steroids to control urticarial symptoms? ☐ Yes – *Submit documentation.* ☐ No
7. <u>For a diagnosis of CIU:</u> Does the patient have a history of trial and failure, contraindication, or intolerance of all of the following at maximal tolerated doses? Check all that apply.
   ☐ H_1 antihistamine ☐ H_2 antihistamine ☐ leukotriene modifier ☐ dapsone, sulfasalazine, or hydroxychloroquine
   ☐ Yes ☐ No
   Submit documentation.
8. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling? ☐ Yes ☐ No

RATIONALE FOR HOSPITAL OUTPATIENT FACILITY TREATMENT SETTING (if applicable):

☐ Documented history of severe adverse reaction occurred during or immediately following an infusion and/or the adverse reaction did not respond to conventional interventions

☐ Documentation that the member is medically unstable for the safe and effective administration of the prescribed medication at an alternative site of care as a result of one of the following:
- ☐ Complex medical condition, status, or therapy requires services beyond the capabilities of an office or home infusion setting (clinical instability or a complex regimen that requires frequent clinical assessment or monitoring, which would be beyond the capabilities of an office or home infusion setting)
- ☐ Documented history of medical instability, significant comorbidity, or concerns regarding fluid status inhibits treatment at a less intensive site of care (unstable fluid status associated with heart failure or advanced [stage 4 or 5] renal failure)

RENEWAL REQUESTS

1. <u>For a diagnosis of asthma,</u> has the patient experienced measurable evidence of improvement in asthma severity? ☐ Yes ☐ No
   Submit documentation of response to therapy.
2. <u>For a diagnosis of chronic idiopathic urticaria,</u> does the patient have documentation of improvement in symptoms and rationale for continued use of Xolair? ☐ Yes ☐ No
   Submit documentation of response to therapy and rationale for continued use.
3. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling? ☐ Yes ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: