

# Pharmacy Prior Authorization Form

Last Reviewed: Sept 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Xolair™ (omalizumab)

Urgent

Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Xolair injection 150 mg

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_ Frequency: \_\_\_\_\_

Patient's weight: \_\_\_\_\_

List the ICD9 code: \_\_\_\_\_

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center

Name of center: \_\_\_\_\_

Home Infusion

Name of agency: \_\_\_\_\_

Billing options:

Physician buy and bill (J2357)

Preferred Specialty Vendor

Other: \_\_\_\_\_

### Priority Health precertification requirements:

#### Authorization of Xolair requires:

- Diagnosis of moderate to severe allergic asthma
- Age at least 12 years
- Documented therapeutic trial of at least 3 months of inhaled corticosteroids as demonstrated by at least one of the following:
  - Hospitalization or ER visit for asthma
  - Requirement for systemic steroids to control asthma exacerbations
  - Increasing need for short-acting inhaled beta 2 agonists for symptoms
- Compliant and persistent use of inhaled corticosteroids
- Positive test for perennial aeroallergen (**lab results must be submitted**)
- IgE level between 30 and 700 IU/ml
- Patient must **not** currently use tobacco

**Continuation of Xolair requires:**

- Peak flow improvement by > 20% OR FEV1 has improved by  $\geq$  12% OR patient has experienced a reduction in symptoms (wheezing, SOB, cough, chest tightness)
- Decrease in relief and/or corticosteroid use (oral or inhaled)
- Decrease in ER visits, hospitalizations, physician visits, OR school/work absences due to acute asthma attacks

**Please Complete the Following Information:**

Diagnosis:

- Moderate to severe allergic asthma
- Other: \_\_\_\_\_ Please provide rationale for use:  
\_\_\_\_\_

New request or continuation of therapy:

- New request (complete Section 1 below)
- Continuation of therapy (complete Section 2 below)
- 

**Section 1: New Request**

Patient's age: \_\_\_\_\_

Patient has not been adequately controlled by inhaled corticosteroids after at least 3 months of therapy, as demonstrated by at least one of the following:

- Hospitalization or ER visit for asthma as the primary diagnosis
- Requirement for systemic (oral, parenteral) corticosteroids to control exacerbations of asthma
- Increasing need (usually > one time a day) for short-acting inhaled beta2 agonist for symptoms (excluding preventive use for exercise-induced asthma)

Patient has demonstrated compliant and persistent use of inhaled corticosteroids (defined as 75% adherence over the past 3 months):

- Yes
- No – Rationale for use: \_\_\_\_\_

Positive test for perennial aeroallergen (**Please submit test results**):

- Yes
- No – Rationale for use: \_\_\_\_\_

IgE level between 30 and 700 IU/ml:      IgE level: \_\_\_\_\_ Date: \_\_\_\_\_

- Yes
- No - Rationale for use: \_\_\_\_\_

Patient currently uses tobacco:

- Yes – Rationale for use: \_\_\_\_\_
- No
-

**Section 2: Continuation of therapy (all of the following are required)**

Peak flow has improved by > 20% OR FEV1 has improved by ≥ 12% OR patient has experienced a reduction in symptoms (wheezing, SOB, cough, chest tightness):

- Yes  
 No – Rationale for use: \_\_\_\_\_

Decrease in the use of quick relief and/or corticosteroid use (oral or inhaled):

- Yes  
 No – Rationale for use: \_\_\_\_\_

Decrease in ER visits, hospitalizations, physician visits, OR school/work absences due to acute asthma attacks:

- Yes  
 No – Rationale for use: \_\_\_\_\_

**Table 1**  
 Administration Every 4 Weeks  
 Xolair Doses (milligrams) Administered by Subcutaneous Injection  
 Every 4 Weeks for Adults and Adolescents 12 Years of Age and Older

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30–60	> 60–70	> 70–90	> 90–150
≥ 30–100	150	150	150	300
> 100–200	300	300	300	<b>SEE TABLE 2</b>
> 200–300	300			
> 300–400				
> 400–500				
> 500–600				

**Table 2**  
 Administration Every 2 Weeks  
 Xolair Doses (milligrams) Administered by Subcutaneous Injection  
 Every 2 Weeks for Adults and Adolescents 12 Years of Age and Older

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30–60	> 60–70	> 70–90	> 90–150
≥ 30–100	<b>SEE TABLE 1</b>			225
> 100–200				
> 200–300		225	225	300
> 300–400	225	225	300	<b>DO NOT DOSE</b>
> 400–500	300	300	375	
> 500–600	300	375		
> 600–700	375			

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\***  
**Please fax this request to: (877)974-4411 toll free or (616)942-8206**  
**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**