PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Xolair® (omalizumab)

Member

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ______________ Gender: ______________

Primary Care Physician: ______________________

Requesting Physician: ______________________ Prov. Phone: ______________ Prov. Fax: ______________

Physician Address: ______________________

Physician NPI: ______________________ Contact Name: ______________________

Physician Signature: ______________________ Date: ______________

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☒ Xolair 150 mg injection

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Dosing frequency: ______________

Patient's weight: ______________

Patient's pre-treatment IgE serum level: ______________

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: ______________ NPI:______________ Fax:______________

☐ Home infusion

Facility: ______________ NPI:______________ Fax:______________

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:______________ NPI:______________ Fax:______________

ICD-10 Diagnosis code(s): ______________________

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 09/2018
Last reviewed 09/2018

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*
2. For a diagnosis of asthma:
   - Must have had a positive skin test or in-vitro reactivity to a perennial aeroallergen
   - Symptoms must be inadequately controlled on inhaled corticosteroids
3. Treatment of chronic urticaria
   - Must be age 12 or older
   - Must first try two or more H1 antihistamines —or—
   - Must try one H1 antihistamine and one or more of the following: H2 antihistamine, oral corticosteroid, leukotriene modifier

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ chronic idiopathic urticaria
☐ IgE-mediated allergic asthma
☐ peanut allergy
☐ subcutaneous immunotherapy
☐ *Other – the patient's condition is:* ______________________________
☐ latex allergy
☐ prevention of allergic rhinitis

B. ***For asthma:*** **Did the patient have a positive skin test or in-vitro reactivity to a perennial aeroallergen?** ☐ Yes ☐ No

C. ***For asthma:*** **Are the patient's symptoms inadequately controlled with inhaled corticosteroids?** ☐ Yes ☐ No

D. ***For idiopathic chronic urticaria:*** **Which other drugs has the patient tried?**

Drug name: ______________________ Dates: ______________
Drug name: ______________________ Dates: ______________
Drug name: ______________________ Dates: __________

PriorityHealth

FDA-approved Dosing Guidelines for Xolair in Patients 12 years old and older

Source: Xolair [package insert]. South San Francisco, CA: Genentech, Inc.; 2010.

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30-60	>60-70	>70-90	>90-150
≥ 30-100	150 mg every 4 weeks	150 mg every 4 weeks	150 mg every 4 weeks	300 mg every 4 weeks
> 100-200	300 mg every 4 weeks	300 mg every 4 weeks	300 mg every 4 weeks	225 mg every 2 weeks
> 200-300	300 mg every 4 weeks	225 mg every 2 weeks	225 mg every 2 weeks	300 mg every 2 weeks
> 300-400	225 mg every 2 weeks	225 mg every 2 weeks	300 mg every 2 weeks	DO NOT DOSE
> 400-500	300 mg every 2 weeks	300 mg every 2 weeks	375 mg every 2 weeks	DO NOT DOSE
> 500-600	300 mg every 2 weeks	375 mg every 2 weeks	DO NOT DOSE	DO NOT DOSE
> 600-700	375 mg every 2 weeks	DO NOT DOSE	DO NOT DOSE	DO NOT DOSE

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Xolair likely be the most effective option for this patient?

☐ No

☐ Yes, because:____

____

____

If the patient is currently using Xolair, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No

☐ Yes, because:____

____

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