PriorityHealth

Medicare Prior Authorization Form

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**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. Priority Health averages between 1 and 3 business days for our standard review response time.

Xolair® (omalizumab)

Reset Form

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

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:
- ☐ Provider's office
- ☐ Outpatient infusion center
- ☐ Home infusion

Center name: _____

Agency name: _____

Billing:
- ☐ Physician buy and bill (J2357)
- ☐ Preferred specialty vendor
- ☐ Other: _____

ICD code(s): _____

Precertification Requirements – *The following information is required for authorization of Xolair:*

Patient must meet one of the following criteria:

1. For coverage under Medicare Part B:
   a. Diagnosis of extrinsic (allergic) asthma
   b. Criteria in CMS local coverage determinations L32013 and L30471 are met
2. For coverage under Medicare Part D:
   a. Treatment of IgE-mediated allergic asthma, latex allergy, peanut allergy or subcutaneous immunotherapy; or for the prevention of allergic rhinitis
   b. Positive skin test or in-vitro reactivity to a perennial aeroallergen (fax a copy of results)
   c. Symptoms must be inadequately controlled with inhaled corticosteroids

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

Last reviewed: September 2013
Last revised: September 2009

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

i. ☐ extrinsic (allergic) asthma
ii. ☐ IgE-mediated allergic asthma
iii. ☐ latex allergy
iv. ☐ peanut allergy
v. ☐ prevention of allergic asthma
vi. ☐ subcutaneous immunotherapy
vii. ☐ Other – rationale for use: _____

The following information is required for coverage under Medicare Part D:

B. Did the patient have a positive skin test or in-vitro reactivity to a perennial aeroallergen?

i. ☐ Yes
ii. ☐ No – rationale for use: _____

C. Are the patient's symptoms inadequately controlled with inhaled corticosteroids?

i. ☐ Yes
ii. ☐ No – rationale for use: _____

PriorityMedicare plans

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

LCD L32013 and L30471

FDA-approved Dosing Guidelines for Xolair

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	
> 500-600	300 mg every 2 weeks	375 mg every 2 weeks		
> 600-700	375 mg every 2 weeks			

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