pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

XOLAIR (omalizumab) (preferred) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Monoclonal Antibodies, Anti-Il, Anti-IgE** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	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

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreens Specialty

Initial Requests		
1. Is Xolair being prescribed by or in consultation with a specialist?	☐Yes ☐No	*Submit documentation of consultation, if applicable.*
2. ***For a diagnosis of asthma:*** Is the beneficiary 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 ☐No	*Submit documentation, including results of allergen reactivity test.*
3. ***For a diagnosis of asthma:*** Does the beneficiary have a serum total IgE measurement between 30 international units (IU)/ml and 1300 IU/ml?	☐Yes ☐No	*Submit documentation of test results.*
4. ***For a diagnosis of asthma:*** Is the beneficiary currently receiving optimally titrated doses, or have a contraindication or intolerance to, any of the following? ☐inhaled glucocorticoid ☐long-acting beta-agonist (LABA) ☐leukotriene modifier ☐other (eg, tiotropium, theophylline): _____	☐Yes ☐No	*Submit documentation of medication regimen and response.*
5. ***For a diagnosis of chronic idiopathic urticaria (CIU):*** Does the beneficiary have a history of urticaria for a period of ≥ 3 months?	☐Yes ☐No	*Submit documentation.*
6. ***For a diagnosis of CIU:*** Does the beneficiary require the use of steroids to control urticarial symptoms?	☐Yes ☐No	*Submit documentation.*
7. ***For a diagnosis of CIU:*** Does the beneficiary 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 ☐leukotriene modifier ☐H_2 antihistamine ☐dapsone, sulfasalazine, or hydroxychloroquine	☐Yes ☐No	*Submit documentation.*
8. Will the beneficiary be monitored and/or treated for helminth infection as recommended in package labeling?	☐Yes ☐No	

Renewal Requests		
1. ***For a diagnosis of asthma***, has the beneficiary experienced measurable evidence of improvement in asthma severity?	☐Yes ☐No	*Submit documentation of response to therapy.*
2. ***For a diagnosis of chronic idiopathic urticaria***, does the beneficiary 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 beneficiary be monitored and/or treated for helminth infection as recommended in package labeling?	☐Yes ☐No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: