

## XOLAIR (omalizumab) PRIOR AUTHORIZATION FORM

Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Xolair** accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:		
<input type="checkbox"/> Renewal request	PA# _____	_____			
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

### CLINICAL INFORMATION

<b>Medication requested:</b> <input type="checkbox"/> Xolair 150 mg vial	<b>Dose/directions:</b>				
<b>Quantity requested:</b> <input type="checkbox"/> # _____ vials (150 mg/vial)	<b>Duration:</b> _____ months	<b>Weight:</b> _____ lbs / kg			
<b>Diagnosis:</b>				<b>Dx code (required):</b>	

#### INITIAL REQUESTS – ASTHMA DIAGNOSIS

1. Check all options that apply to the Recipient and *submit documentation for each, including chart notes, test results, and medication history.*
- diagnosis of asthma that is confirmed by ALL of the following:
- medical history & physical exam findings
  - spirometry results that demonstrate obstruction
  - asthma is allergen-induced as confirmed by a positive skin test OR radioallergosorbent test (RAST) to an unavoidable perennial aeroallergen
  - serum total IgE measurement between 30 IU/mL and 700 IU/mL
  - trial & failure, contraindication, or intolerance of maximal therapeutic doses of asthma controller medications
  - asthma is graded as moderate to severe persistent despite use of tolerated doses of asthma controller medications confirmed by 1 or more of the following:
    - daily asthma symptoms, such as coughing, wheezing, and dyspnea
    - daily use of a rescue inhaler, such as a beta-2 agonist (i.e., albuterol, levalbuterol)
    - ≥ 2 asthma exacerbations per year that require the use of oral systemic corticosteroids
- reversibility demonstrated by either an increase in FEV<sub>1</sub> of ≥ 12% from baseline OR an increase of ≥ 10% of predicted FEV<sub>1</sub>
- ≥ 1 night per week of nocturnal asthma causing awakening
- FEV<sub>1</sub> ≤ 80%

#### INITIAL REQUESTS – CHRONIC IDIOPATHIC URTICARIA DIAGNOSIS

- |  |   |   |
|--|---|---|
| 1. Does the Recipient have a history of urticaria for a period of ≥ 3 months?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <i>Submit documentation.</i>  |
| 2. Does the Recipient require the use of steroids to control urticarial symptoms?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <i>Submit documentation.</i>  |
| 3. Does the Recipient have a history of trial and failure, contraindication, or intolerance of all of the following at maximal tolerated doses? <i>Check all that apply.</i> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <i>Submit documentation of all medications tried and treatment outcomes or contraindications and/or intolerances.</i> |

#### RENEWAL REQUESTS

- |   |   |   |
|---|---|---|
| 1. <b>For a diagnosis of asthma</b> , has the Recipient experienced measurable evidence of improvement in asthma severity?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <i>Submit documentation of Recipient's response to therapy.</i>                                 |
| 2. <b>For a diagnosis of chronic idiopathic urticaria</b> , does the Recipient have documentation of improvement in symptoms and rationale for continued use of Xolair? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <i>Submit documentation of Recipient's response to therapy and rationale for continued use.</i> |

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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