Xolair (omalizumab) Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | Credentials | Specialty | Board-certified in Specialty ☐ Yes ☐ No

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Select one:

☐ Xolair vials ☐ Xolair autoinjectors ☐ Xolair syringes

Strength | Route of Administration

NOTE: Xolair vials are preferred. Approval of Xolair autoinjectors or syringes would additionally require each of the following criteria to be met:

- *The patient must have previously attempted and failed each of the other preferred agents in this class indicated for the diagnosis.*
- *The patient must have previously received at least three doses of Xolair.*
- *The medication will be administered by the patient or personal caregiver (Xolair autoinjectors/syringes will not be approved for administration by a medical provider).*

Directions | Diagnosis | ICD Diagnosis Code (if available)

Previous Treatment History

Please list all medications the patient has previously attempted for the diagnosis being treated along with the dose/directions attempted, the start date of the trial, the end date of the trial, and the reason for discontinuing.

Please also complete the appropriate section for the diagnosis being treated:

Asthma

Does the patient have a diagnosis of moderate to severe persistent allergic asthma? ☐ Yes ☐ No

Has the patient reacted positively to a perennial aeroallergen skin or blood test? ☐ Yes ☐ No
If yes, please attach results.

Is the patient a current smoker? ☐ Yes ☐ No

If yes, is the patient currently enrolled in a smoking cessation program? ☐ Yes ☐ No
(WV Medicaid members can enroll in smoking cessation counseling at no charge by calling 1-800-QUITNOW)

Patient's weight (in kg)	Date measured	Baseline IgE level *(please attach lab)*	Date measured

Chronic Spontaneous Urticaria (formerly Chronic Idiopathic Urticaria)

Have other diagnoses associated with chronic urticaria been ruled out? ☐ Yes ☐ No

Rhinosinusitis with Nasal Polyps

Will the patient continue taking an intranasal corticosteroid concurrently with Xolair if it is approved? ☐ Yes ☐ No

If yes, please document which intranasal corticosteroid will be prescribed concurrently:

Patient's weight (in kg)	Date measured	Baseline IgE level *(please attach lab)*	Date measured

IgE-mediated Food Allergy

Please indicate the food(s) the patient is allergic to (check all that apply):

☐ Cashew ☐ Egg ☐ Hazelnut ☐ Milk ☐ Peanut

☐ Walnut ☐ Wheat ☐ Other (please list)

Does the patient have a positive skin prick test (at least 4 mm wheal) to each of the above foods? ☐ Yes ☐ No
If yes, please attach results.

Does the patient have either a positive food-specific IgE (at least 6 kUA/L) to each of the above foods OR a positive double-blind placebo-controlled food challenge (experiencing dose-limiting symptoms at a single dose of less than or equal to 100mg of peanut protein or 300mg of food protein)? ☐ Yes ☐ No

If yes, please indicate which test was performed

☐ Food-specific IgE level *(please attach lab report)* ☐ Double-blind placebo-controlled food challenge *(please attach testing note)*

Does the patient have a history of a severe (type 1) allergic reaction requiring an emergency room visit or hospitalization due to symptoms of wheezing, angioedema, and/or hives/urticaria that occurred within a short period of time following a known ingestion of the above food(s)? ☐ Yes ☐ No

Is the patient prescribed a rescue medication to be used in the event of an anaphylactic reaction to the above food(s)? ☐ Yes ☐ No

If yes, please document the rescue medication prescribed

Will Xolair be prescribed in conjunction with a food allergen avoidance diet? ☐ Yes ☐ No

Will the patient be prescribed any other monoclonal antibody therapy concurrently with Xolair (whether for the treatment of this condition or another condition)? ☐ Yes ☐ No

If yes, please list which monoclonal antibody medication(s) will be prescribed concurrently with Xolair:

Patient's weight (in kg)	Date measured	Baseline IgE level *(please attach lab)*	Date measured

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)