

**Request for Prior Authorization
OMALIZUMAB (XOLAIR)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy.

Nasal Polyps:

1. Patient has a diagnosis of nasal polyps; and
2. Patient has documentation of an adequate trial and inadequate response with at least two nasal corticosteroids at a maximally tolerated dose; and
3. Will be used concurrently with a nasal corticosteroid.

If criteria for coverage are met, the initial authorization will be given for 24 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid.

IgE Mediated Food Allergy:

1. Medication is being prescribed for the reduction of allergic reactions (Type 1) that may occur with accidental exposure to one or more foods in a patient that has an IgE-mediated food allergy; and
2. Diagnosis is confirmed by a skin prick test or in vitro test (attach results); and
3. Will be used in conjunction with food allergen avoidance.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

Xolair prefilled syringe

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Was therapy initiated in a healthcare setting, under the guidance of a healthcare provider for a minimum of 3 doses? Yes Date dose 1: _____ Date dose 2: _____ Date dose 3: _____ No

Has healthcare provider determined self-administration is appropriate based on careful assessment of risk for anaphylaxis and mitigation strategies, as outlined in the label? Yes No

Prescriber Specialty: Allergist Dermatologist Immunologist Otolaryngologist Pulmonologist
Other (specify): _____

Patient has access to epinephrine injection: Yes No

Has patient been educated on proper storage and administration? Yes No

Pretreatment IgE level: _____ Date Obtained: _____

Patient's Weight (kg): _____ Date Obtained: _____

Moderate to Severe Persistent Asthma:

Date of diagnosis: _____

Inhaled Corticosteroid trial: Drug Name: _____ Strength: _____ Instructions: _____

Trial dates: _____

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Inhaled Long-Acting Beta-Agonist trial: Drug Name: _____ Strength: _____ Instructions: _____

Trial dates: _____

Leukotriene Receptor Antagonist trial: Drug Name: _____ Strength: _____ Instructions: _____

Trial dates: _____

Medical or contraindication reason to override trial requirements: _____

History of positive skin or RAST test to a perennial aeroallergen: Yes No Date Performed: _____

For Renewals Only: Has patient shown adequate response to Xolair[®] therapy? Yes No

Please describe: _____

Moderate to Severe Chronic Idiopathic Urticaria:

Preferred Second-Generation Antihistamine trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Preferred First-Generation Antihistamine trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Preferred Potent H1 receptor antagonist trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Preferred Leukotriene Receptor Antagonist in combination with a preferred first-or second- generation antihistamine:

Preferred Leukotriene Receptor Antagonist trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Preferred First-or Second-Generation Antihistamine trial: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

For Renewals Only: Has patient shown adequate response to Xolair[®] therapy? Yes No

Please describe: _____

Nasal Polyps:

Nasal Corticosteroid Trials:

Trial 1: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Trial 2: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial dates: _____

Will omalizumab be used concurrently with a nasal corticosteroid? Yes Drug Name: _____ No

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For Renewals Only: Has patient shown adequate response to Xolair[®] therapy? Yes No

Please describe: _____

Is patient currently using a nasal corticosteroid? Yes No

IgE Mediated Food Allergy:

Is medication being prescribed for the reduction of Type 1 allergic reactions that may occur with accidental exposure to one or more foods in a patient that has an IgE-mediated food allergy? Yes No

Is diagnosis confirmed by a skin prick test or in vitro test? Yes (attach results) No

Will requested medication be used in conjunction with food allergen avoidance? Yes No

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*