

**State of Oklahoma
SoonerCare
Xolair[®] (Omalizumab) Prior Authorization Form**

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____) **Pharmacy billing* (NDC: _____)**

*If medication is being billed by a pharmacy, the medication should be shipped to the health care facility where it will be administered.

Dose: _____ **Regimen:** _____ **Fill Date:** _____

Billing Provider Information

SoonerCare Provider ID: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Name of outpatient health care facility where Xolair[®] will be delivered to and administered at:

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Clinical Information

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Page 1 of 3—Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization:

1. What is the diagnosis for which the medication is being prescribed?

- Severe Persistent Asthma [as per National Asthma Education and Prevention Program guidelines]**
- Chronic Idiopathic Urticaria**
- Nasal Polyps**
- Immunoglobulin E (IgE)-Mediated Food Allergy**
- Other, please list:** _____

Please select one option only:

For Xolair[®] in a health care facility

a. Will the injection be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes ___ No ___

For Xolair[®] prefilled autoinjector or prefilled syringe for self-administration

a. Does member have a prior history of anaphylaxis? Yes ___ No ___

b. Has member had at least 3 doses of Xolair[®] under the guidance of a health care provider with no hypersensitivity reactions? Yes ___ No ___

c. Has member been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Xolair[®]? Yes ___ No ___

A. Was Xolair[®] prescribed by a specialist or has the member been evaluated by a specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is specialist)? Yes ___ No ___

i. If "Yes", please include name of specialist: _____ Specialty: _____

B. Please provide member's baseline IgE level: _____ IU/mL

C. Please provide member's weight: _____ kg Date taken: _____

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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2. If diagnosis is **Severe Persistent Asthma**, please provide the following (*Initial approvals will be for the duration of 6 months*):
 - A. Does member have a positive skin test to at least 1 perennial aeroallergen? Yes ___ No ___
 - i. If "Yes", please list perennial aeroallergen(s): _____
 - B. Has member failed a medium to high-dose ICS used compliantly within the last 3-6 consecutive months? Yes ___ No ___
 - i. Drug/Dose: _____
 - C. Please provide the places and dates of asthma related hospitalizations and/or ER visits in the past 12 months: _____
 - D. Is member dependent on systemic corticosteroids to prevent serious asthma exacerbations? Yes ___ No ___
3. If diagnosis is **Chronic Idiopathic Urticaria**, please provide the following (*Initial approvals will be for the duration of 3 months*):
 - A. Have other forms of urticaria been ruled out? Yes ___ No ___
 - B. Have other potential causes of urticaria been ruled out? Yes ___ No ___
 - C. Please provide member's Urticaria Activity Score (UAS): _____ Date assessed: _____
 - D. Has the member had a trial of a second generation H₁ antihistamine dosed 4 times the maximum FDA dose within the last 3 months for at least 4 weeks? Yes ___ No ___
 - i. If "Yes", please provide the medication used, dose prescribed, and dates of use:
Medication: _____ Dose: _____ Dates of use: _____
 - ii. If the second generation H₁ antihistamine trial duration was less than 4 weeks, please provide a reason why a 4-week trial is not appropriate for this member: _____
4. If diagnosis is **Nasal Polyps**, please provide the following (*Initial approvals will be for the duration of 6 months*):
 - A. Will Xolair® be used for add-on maintenance treatment of nasal polyps after an inadequate response to nasal corticosteroids? Yes ___ No ___
 - B. Has the member had a trial of intranasal corticosteroids for, at minimum, the past 4 weeks? Yes ___ No ___
 - i. If "Yes", please provide the medication used and dates of use:
Medication: _____ Dates of use: _____
 - C. Will the member continue to receive intranasal corticosteroid therapy? Yes ___ No ___
 - i. If "No", does the member have a contraindication to intranasal corticosteroid therapy? Yes ___ No ___
 1. If "Yes", please provide the member's contraindication: _____
 - D. Does the member have symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management? Yes ___ No ___
 - E. Does the member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy? Yes ___ No ___

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5. If diagnosis is **Immunoglobulin E-Mediated Food Allergy**, please provide the following (*Initial approvals will be for the duration of 1 year*):
- A. Is member’s diagnosis a peanut, milk, egg, wheat, cashew, hazelnut or walnut allergy confirmed by a positive skin test, positive in vitro test for food-specific IgE, or positive clinician supervised oral food challenge? Yes ___ No ___
 - i. If “Yes”, please list the member’s allergies: _____
 - ii. Please list the method used to confirm the allergy diagnosis listed above: _____

****Documentation of allergy testing results must be submitted****
 - B. Will Xolair® be used with an allergen-avoidant diet? Yes ___ No ___
 - C. Is the member or family member trained in the use of an auto-injectable epinephrine device and will have such a device available for immediate use at all times? Yes ___ No ___

For Continued Authorization:

- 1. Is the member compliant with therapy? Yes ___ No ___
- 2. Is the member responding well to therapy? Yes ___ No ___
- 3. If member’s diagnosis includes **Chronic Idiopathic Urticaria**, please provide member’s current Urticaria Activity Score (UAS): _____ Date assessed: _____
 - a. If there has been no improvement in member’s UAS score, please provide additional clinical information to support the continuation of Xolair® treatment: _____

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member’s drug history will be reviewed prior to approval.

Prescriber Signature: _____ **Date:** _____
 (By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

Pharmacist Signature: _____ **Date:** _____

Pease do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

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