



# State of Oklahoma SoonerCare

## Omlyclo<sup>®</sup> (omalizumab-igec) & Xolair<sup>®</sup> (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

Provider NPI: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Name of outpatient health care facility where medication will be delivered to and administered at: \_\_\_\_\_

### Prescriber Information

Prescriber NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

### Clinical Information

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 Global Initiative for Asthma (GINA)]
- Chronic Spontaneous Urticaria
- Nasal Polyps
- Immunoglobulin E (IgE)-Mediated Food Allergy
- Other, please list: \_\_\_\_\_

#### Please select one option only:

For administration 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 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 requested medication 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 requested medication? Yes \_\_\_ No \_\_\_

A. Was requested medication 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: \_\_\_\_\_

D. For Omlyclo<sup>®</sup>, a patient-specific, clinically significant reason why the member cannot use Xolair<sup>®</sup>: \_\_\_\_\_

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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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State of Oklahoma
SoonerCare

Omlyclo® (omalizumab-igec) & Xolair® (omalizumab) Prior Authorization Form

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Clinical Information

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- 2. If diagnosis is Severe Persistent Asthma [as per Global Initiative for Asthma (GINA), 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 Spontaneous 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. Please provide member's Urticaria Activity Score (UAS):\_\_\_\_\_ Date assessed: \_\_\_\_\_
C. 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 the requested product 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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Clinical Information

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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 the requested product 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 Spontaneous 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:

Additional Information:

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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:

Please 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.

Table with 2 columns: 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) and CONFIDENTIALITY NOTICE (This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.)