OKLAHOMA
Health Care Authority

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 2—Please complete and return <u>all</u> 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**
   - ❑ Other, please list:_____
   - A. Will Xolair® be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes☐ No☐
   - B. 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:_____
   - C. Please provide member's baseline IgE level:_____ IU/mL
   - D. Please provide member's weight: _____kg Date taken:_____
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 high-dose inhaled corticosteroid (≥880 mcg/day fluticasone propionate or equivalent daily dose or ≥440 mcg/day in ages 12 to 17 years) used compliantly for at least the past 12 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: _____

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>	<u>CONFIDENTIALITY NOTICE</u>
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	*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.*

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

Clinical Information

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For Initial Authorization, continued:

3. If diagnosis is **Chronic Idiopathic Urticaria**, please provide the following, continued:
   D. Has the member had a trial of a second generation H_1 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 H_1 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☐

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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