https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Xolair (omalizumab)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 Provider Help Desk: 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Xolair (omalizumab)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for Xolair®. Payment for Xolair will be authorized when the following criteria are met:

For moderate to severe persistent asthma: 1) Patient has a diagnosis of moderate to severe persistent asthma for at least one year, 2) Patient is 6 years of age or older, 3) Medication will be administered by a health care professional in the member's home by home health or in a long-term care facility, 4) Pre-treatment IgE level is within the following range: Adults and adolescent patients 12 years of age or older- 30 IU/mL to 700 IU/mL; pediatric patients 6 to less than 12 years of age - 30 IU/mL to 1300 IU/mL, 5) Patient's weight is within the following range: adults and adolescent patients 12 years of age or older: 30 kg to 150 kg; pediatric patients 6 to less than 12 years of age - 20 kg to 150 kg, 6) History of positive skin or RAST test to a perennial aeroallergen, 7) Prescriber is an allergist, immunologist or pulmonologist, 8) Patient is currently using a high dose inhaled corticosteroid, long-acting beta-agonist AND leukotriene receptor antagonist and is compliant with therapy, and asthma symptoms are not adequately controlled after at least three months of therapy, 9) Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight, 10) Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of Xolair.

If the criteria for coverage are met, the initial authorization will be given for 16 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 Xolair therapy and for patients who do not continue concurrent use with a high-dose inhaled corticosteroid, long-acting beta-agonist and leukotriene receptor antagonist.

For chronic idiopathic urticaria: 1) Patient has a diagnosis of moderate to severe chronic urticarial, 2) Patient is 12 years of age or older, 3) Medication is to be administered by a health care professional in the member's home by home health or in a long-term care facility, 4) Patient has documentation of a trial and therapy failure with at least one preferred second-generation antihistamine, one of which must be cetirizine at a dose up to 20 mg per day, 5) Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine, 6) Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin), 7) Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine.

If criteria for coverage are met, the initial authorization will be for 12 weeks to assess the need for continued therapy. Required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Patient name: _____ **Patient ID #:** _____

Please indicate setting in which Xolair is to be administered: _____

Moderate to severe persistent asthma: ☐ Mild ☐ Moderate ☐ Severe

Inhaled corticosteroid trial: Drug name: _____ Strength: _____ Instructions: _____

Trial date from: _____ Trial date to: _____

Inhaled long-acting beta-agonist trial: Drug name: _____ Strength: _____ Instructions: _____

Trial date from: _____ Trial date to: _____

Leukotriene receptor antagonist trial: Drug name: _____ Strength: _____ Instructions: _____

Trial date from: _____ Trial date to: _____

Medical or contraindication reason to override trial requirements: _____

Pretreatment IgE level: _____ Date obtained: _____

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

Is Xolair being dosed according to manufacturer labeling based on pretreatment serum IgE and body weight: ☐ Yes ☐ No

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

Please state prescriber's specialty: _____

Patient has access to epinephrine injection: ☐ Yes ☐ No

For renewals only: Has patient shown adequate response to Xolair® therapy? ☐ Yes ☐ No

Please describe: _____

Chronic Idiopathic urticaria: ☐ Mild ☐ Moderate ☐ Severe

Preferred second-generation antihistamine trial: Drug name: _____ Strength: _____

Dosing instructions: _____ Trial start and end dates from: _____

Preferred first-generation antihistamine trial: Drug name: _____ Strength: _____

Dosing instructions: _____ Trial start and end dates from: _____

Preferred potent H1 receptor antagonist trial: Drug name: _____ Strength: _____

Dosing instructions: _____ Trial start and end dates from: _____

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 start and end dates from: _____

Preferred first-or second-generation antihistamine trial: Drug name: _____ Strength: _____

Dosing instructions: _____ Trial start and end dates from: _____

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Patient name: _____ **Patient ID #:** _____

For renewals only: Has patient shown adequate response to Xolair® therapy? ☐ Yes ☐ No

Please describe: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

9. PHYSICIAN SIGNATURE

_____ _____

Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.