Amerigroup

Medicaid

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Xolair
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

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			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.)

Initial request

□ Yes □ No Does the client have a diagnosis of moderate to severe persistent asthma in the last 730 days?

□ Yes □ No Has the client had a positive skin test or in vitro reactivity to a perennial aeroallergen in the last 5 years?

□ Yes □ No Does the client have at least 60 days therapy with an inhaled corticosteroid (ICS) in the last 90 days OR does the client have an intolerance, hypersensitivity, or contraindication to inhaled corticosteroids?

□ Yes □ No Does the client have at least 60 days therapy with a long-acting beta agonist (LABA), leukotriene modifier (LTM), long-acting muscarinic antagonist (LAMA) or theophylline in the last 90 days OR does the client have an intolerance or hypersensitivity to all classes listed?

□ Yes □ No Is the client's pretreatment IgE level ≥ 30 IU/mL and ≤ 700 IU/mL (12 years and older) OR ≥ 30 IU/mL and ≤ 1300 IU/mL (6 to < 12 years of age)?

□ Yes □ No Does the client weigh more than 150kg?

□ Yes □ No Is the requested dose (based on the client's pretreatment serum IgE level and body weight) equal to the dose defined in the FDA labeling, not to exceed 375 mg every 2 weeks?

□ Yes □ No Does the client have a diagnosis of chronic spontaneous urticaria (CSU) in the last 730 days?

□ Yes □ No Does the client have at least 60 days therapy with an H1 antihistamine in the last 90 days OR is does the client have an intolerance, hypersensitivity, or contraindication to all H1 antihistamines?

□ Yes □ No Does the client have a diagnosis of nasal polyps in the last 730 days?

□ Yes □ No Does the client have at least 90 days therapy with an intranasal corticosteroid (INC) in the last 120 days OR does the client have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?

□ Yes □ No Is the client's pretreatment IgE level ≥ 30 IU/mL and ≤ 1500 IU/mL?

□ Yes □ No Will the client have concurrent therapy with another monoclonal antibody agent indicated for the treatment of asthma, chronic spontaneous urticaria or nasal polyps?

Renewal request

□ Yes □ No Does the client have a diagnosis of moderate to severe persistent asthma in the last 730 days?

□ Yes □ No Does the client have current therapy with an inhaled corticosteroid that will continue during therapy with Xolair OR does the client have an intolerance, hypersensitivity, or contraindication to inhaled corticosteroids?

□ Yes □ No Does the client weigh more than 150kg?

□ Yes □ No Does the client have a diagnosis of chronic spontaneous urticaria in the last 730 days?

□ Yes □ No Does the client have a diagnosis of nasal polyps in the last 730 days?

□ Yes □ No Does the client have current therapy with an intranasal corticosteroid that will continue during therapy with Xolair OR does the client have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?

□ Yes □ No Does the client weigh more than 150kg?

□ Yes □ No Will the client have concurrent therapy with another monoclonal antibody agent indicated for the treatment of asthma, chronic spontaneous urticaria or nasal polyps?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

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.

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