Iowa Department of Human Services

Request for Prior Authorization
OMALIZUMAB- (XOLAIR®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Xolair®. Payment for Xolair® will be authorized when the following criteria are met: Moderate to Severe Persistent Asthma: 1) Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and 2) Patient is 6 years of age or older; and 3) Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility; and 4) Pretreatment IgE level is within the following range: Adults and adolescent patients 12 years of age or older- 30 IU/mL to 700 IU/mL or Pediatric patients 6 to less than 12 years of age- 30 IU/mL to 1300 IU/mL; and 5) Patient's weight is within the following range: Adults and adolescent patients 12 years of age or older 30 kg to 150 kg or Pediatric patients 6 to less than 12 years of age- 20 kg to 150 kg; and 6) History of positive skin or RAST test to a perennial aeroallergen; and 7) Prescriber is an allergist, immunologist or pulmonologist; and 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 (3) months of therapy; and 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. Chronic Idiopathic Urticaria: 1) Patient has a diagnosis of moderate to severe chronic urticaria; and 2) Patient is 12 years of age or older; and 3) Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility; and 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 20mg per day; and 5) Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and 6) Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and 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 given for 12 weeks to assess the need for continued therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

Xolair ☐

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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: _____

Request for Prior Authorization
OMALIZUMAB- (XOLAIR®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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 & end dates from: _____

Preferred First-Generation Antihistamine trial: Drug Name: _____Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

Preferred Potent H1 receptor antagonist trial: Drug Name: _____Strength: _____
Dosing Instructions: _____ Trial start & 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 & end dates from: _____

Preferred First-or Second-Generation Antihistamine trial: Drug Name: _____Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

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.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*