PRIOR AUTHORIZATION REQUEST
Xolair

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Will Xolair be used in combination with an anti- interleukin monoclonal antibody (for example, Cinqair, Fasenra, Nucala, Dupixent)?
2. What is the indication or diagnosis?
   - ☐ Asthma – **Please answer questions 3 - 12**
   - ☐ Chronic idiopathic urticaria (chronic spontaneous urticaria) – **Please answer questions 3 – 4, 13 - 15**
   - ☐ Eosinophilic colitis
   - ☐ Eosinophilic esophagitis (EE)
   - ☐ Eosinophilic gastroenteritis (EG)
   - ☐ Treatment of peanut and other food allergies
   - ☐ Treatment of atopic dermatitis
   - ☐ Treatment of latex allergy in health care workers with occupational latex allergy
   - ☐ Treatment of chronic rhinosinusitis
   - ☐ All other indications or diagnoses (Please specify): _____
3. ☐ Yes ☐ No Is the patient currently receiving Xolair?
4. ☐ Yes ☐ No Has the patient already received at least 4 months of therapy with Xolair?
5. ☐ Yes ☐ No Will the patient continue to receive therapy with one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler?
6. ☐ Yes ☐ No Has the prescriber determined that the patient has responded to therapy?
7. ☐ Yes ☐ No Is this medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
8. ☐ Yes ☐ No Does the patient have a baseline (prior to treatment with Xolair or anti-interleukin-4/13 therapy [Dupixent]) immunoglobulin E (IgE) level greater than or equal to 30 IU/ml?
9. ☐ Yes ☐ No Has the patient had a baseline (prior to treatment with Xolair) positive skin test or in vitro test (i.e. a blood test) for allergen-specific immunoglobulin E (IgE) for one or

PRIOR AUTHORIZATION REQUEST
Xolair

more perennial aeroallergens AND/OR for one or more seasonal aeroallergens?

10. ☐ Yes ☐ No Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following: an inhaled corticosteroid AND at least one additional asthma controller/maintenance medication.
11. ☐ Yes ☐ No Has the patient already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an inhaled corticosteroid for at least 3 consecutive months?
12. ☐ Yes ☐ No Does the patient's asthma continue to be uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following: the patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR the patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year; OR the patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted; OR the patient has an FEV1/forced vital capacity (FVC) less than 0.80; OR the patient's asthma worsens upon tapering of oral corticosteroid therapy?
13. ☐ Yes ☐ No Has the prescriber determined that the patient has responded to therapy? Note: Examples of a response to Xolair therapy are decreased severity of itching, decreased number and/or size of hives.
14. ☐ Yes ☐ No Is this medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist?
15. ☐ Yes ☐ No Has the patient had urticaria for more than 6 weeks (prior to treatment with Xolair), with symptoms present more than 3 days per week despite daily non-sedating H1-antihistamine therapy with doses that have been titrated up to a maximum of four times the standard FDA-approved dose?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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If you have any questions, call: 800-753-2851

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Xolair

authorization as per Plan policy and procedures.

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