maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Xolair

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with another anti-Interleukin monoclonal antibody therapy? [If yes, no further questions.]	Yes	No
2	What is the indication or diagnosis? [] Asthma (If checked, go to 3) [] Atopic dermatitis (If checked, no further questions) [] Chronic Idiopathic Urticaria (Chronic Spontaneous Urticaria) (If checked, go to 25)		

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1-888-258-8250

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	[] Chronic Rhinosinusitis (If checked, no further questions)		
	[] Eosinophilic colitis (If checked, no further questions)		
	[] Eosinophilic esophagitis (If checked, no further questions)		
	[] Eosinophilic gastroenteritis (If checked, no further questions)		
	[] Nasal polyps (If checked, go to 36)		
	[] Treatment of latex allergy in health care workers with occupational latex allergy (If checked, no further questions)		
	[] IgE mediated food allergies (If checked, go to 54)		
	[] Other (If checked, no further questions)		
3	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, no further questions.]	Yes	No
4	Does the prescribed dose exceed 375 mg every 2 weeks? [If yes, no further questions.]	Yes	No
5	Is patient's weight 20 kg to 150 kg? [If no, no further questions.]	Yes	No
6	Is the patient currently receiving requested medication? [If no, skip to question 13.]	Yes	No
7	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 13.]	Yes	No
8	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 13.]	Yes	No
9	Has the patient already received at least 4 months of therapy with the requested medication? [Note: A patient who has received less than 4 months of therapy or who is restarting therapy with the requested medication should be considered under Initial Therapy.] [If no, skip to question 13.]	Yes	No
10	Does the patient have a documented clinical response to therapy as determined by the prescriber?	Yes	No

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	[Note: Examples of a response to the requested medication are asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department (ED)/urgent care, or medical clinic visits due to asthma; decreased reliever/rescue medication use; and improved lung function parameters.] [If no, no further questions.]		
11	Does the patient continue to receive therapy with one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler? [If no, no further questions.]	Yes	No
12	Will the patient be concurrently receiving requested medication in combination with any anti-IL4, anti-IL5, TSLP inhibitor therapies such as Dupixent, Nucala, Cinqair, Fasenra, and Tezspire? [No further questions.]	Yes	No
13	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
14	Has documentation been provided to confirm that the patient has a baseline (prior to treatment with Xolair or anti-interleukin-4/13 therapy [Dupixent]) immunoglobulin E (IgE) level 30 IU/mL to 1300 IU/mL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the patient have a baseline (prior to treatment with Xolair) positive skin test or in vitro test (that is, a blood test) for allergen-specific immunoglobulin E (IgE) for one or more perennial aeroallergens AND/OR for one or more seasonal aeroallergens? [Note: Examples of perennial aeroallergens are house dust mite, animal dander, cockroach, feathers, and mold spores. Examples of seasonal aeroallergens are grass, pollen, and weeds.] [If no, no further questions.]	Yes	No
16	Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following unless contraindicated or intolerant to at least two inhaled corticosteroid containing medications: A) An inhaled corticosteroid AND B) At least one additional asthma controller/maintenance medication? [Note: Examples of additional asthma controller/maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, and theophylline. Use of a combination inhaler containing both an inhaled corticosteroid and a long-acting beta2-agonist would fulfil the requirement for both criteria A and B.] [If yes, skip to question 18.]	Yes	No
17	Has the patient already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an inhaled corticosteroid for at least 3 consecutive months? [If no, no further questions.]	Yes	No

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18	Do the patient and prescriber agree to continue asthma therapy with an asthma controller maintenance medication in conjunction with the requested medication: inhaled corticosteroids (ICS) or ICS combination inhaler? [If no, no further questions.]	Yes	No
19	Is the patient's asthma uncontrolled or was uncontrolled prior to receiving the requested medication or anti-IL-4/13 therapy (Dupixent) therapy as defined by the following: the patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? [If yes, skip to question 24.]	Yes	No
20	Is the patient's asthma uncontrolled or was uncontrolled prior to receiving the requested medication or anti-IL-4/13 therapy (Dupixent) therapy as defined by the following: the patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year? [If yes, skip to question 24.]	Yes	No
21	Is the patient's asthma uncontrolled or was uncontrolled prior to receiving the requested medication or anti-IL-4/13 therapy (Dupixent) therapy as defined by the following: the patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted? [If yes, skip to question 24.]	Yes	No
22	Is the patient's asthma uncontrolled or was uncontrolled prior to receiving the requested medication or anti-IL-4/13 therapy (Dupixent) therapy as defined the following: the patient has an FEV1/forced vital capacity (FVC) less than 0.80? [If yes, skip to question 24.]	Yes	No
23	Is the patient's asthma uncontrolled or was uncontrolled prior to receiving the requested medication or anti-IL-4/13 therapy (Dupixent) therapy as defined by the following: the patient's asthma worsens upon tapering of oral corticosteroid therapy? [If no, no further questions.]	Yes	No
24	Will the patient be concurrently receiving the requested medication in combination with any anti-IL4, anti-IL5, TSLP inhibitor therapies such as Dupixent, Nucala, Cinqair, Fasenra, and Tezspire? [No further questions.]	Yes	No
25	Has the patient been evaluated for other causes of urticaria (bradykinin-related angioedema, auto-inflammatory disorders, urticarial vasculitis)? [If no, no further questions.]	Yes	No
26	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No

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27	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
28	Will the patient be concurrently receiving Xolair in combination with any anti-IL4, anti-IL5, TSLP inhibitor therapies such as Dupixent, Nucala, Cinqair, Fasenra, and Tezspire? [If yes, no further questions.]	Yes	No
29	Is the patient currently receiving requested medication? [If no, skip to question 34.]	Yes	No
30	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 34.]	Yes	No
31	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 34.]	Yes	No
32	Has the patient been established on therapy for at least 4 months and had a documented clinically significant response, as determined by the prescriber? [Note: Examples of a response to Xolair therapy are decreased severity of itching, decreased number and/or size of hives.] [If no, skip to question 34.]	Yes	No
33	Does the patient have a documented clinical response to therapy as determined by the prescriber? [Note: Examples of a response to Xolair therapy are decreased severity of itching, decreased number and/or size of hives.] [No further questions.]	Yes	No
34	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
35	Does the patient remain symptomatic despite a 4-week trial with at least one H1 antihistamine in combination with a leukotriene receptor antagonist (LTRA), or H2 antihistamine, or another H1 antihistamine with doses that have been titrated up to a maximum of four times the standard FDA-approved dose, unless contraindicated or intolerant? [Note: Examples of H1 antihistamine therapy are cetirizine, desloratadine, fexofenadine, levocetirizine, and loratadine.] [No further questions.]	Yes	No
36	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
37	Does the patient have chronic rhinosinusitis with nasal polyposis as evidenced by	Yes	No

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	direct examination, endoscopy, or sinus computed tomography (CT) scan? [If no, no further questions.]		
38	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist (ear, nose and throat [ENT] physician specialist)? [If no, no further questions.]	Yes	No
39	Will the patient concurrently be receiving the requested medication with any anti-IL4, anti-IL5, or TSLP inhibitor such as Dupixent, Cinqair, Fasenra, or Tezspire? [If yes, no further questions.]	Yes	No
40	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
41	Is the patient currently receiving the requested medication? [If no, skip to question 47.]	Yes	No
42	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 47.]	Yes	No
43	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 47.]	Yes	No
44	Has the patient already received at least 4 months of therapy with the requested medication? [Note: A patient who has received less than 4 months of therapy or who is restarting therapy with the requested medication should be considered under Initial Therapy.] [If no, skip to question 47.]	Yes	No
45	Does the patient have a documented clinical response to therapy as determined by the prescriber? [Note: Examples of a response to the requested medication are reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, and/or improved sense of smell.] [If no, no further questions.]	Yes	No
46	Will the patient receive the requested medication as an add on maintenance therapy in combination with an intranasal corticosteroid unless contraindicated or intolerant? [No further questions.]	Yes	No
47	Has the patient experienced TWO or more of the following symptoms for at least 6 months: A) Nasal congestion, B) Nasal obstruction, C) Nasal discharge, and/or D)	Yes	No

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	reduction/loss of smell? [If no, no further questions.]		
48	Does the patient have a baseline immunoglobulin E (IgE) level greater than or equal to 30 IU/mL? [Note: "Baseline" is defined as prior to receiving any Xolair or anti-interleukin-4/13 therapy (that is, Dupixent [dupilumab subcutaneous injection]).] [If no, no further questions.]	Yes	No
49	Has the patient received at least 3 months of therapy with an intranasal corticosteroid, unless contraindicated or intolerant to two products? [If no, no further questions.]	Yes	No
50	Will the patient receive the requested medication as an add on maintenance therapy in combination with an intranasal corticosteroid unless contraindicated or intolerant? [If no, no further questions.]	Yes	No
51	Has the patient received at least one course of treatment with a systemic corticosteroid for 5 days or more within the previous 2 years? [If yes, no further questions.]	Yes	No
52	Does the patient have a contraindication to systemic corticosteroid therapy? [If yes, no further questions.]	Yes	No
53	Has the patient had prior surgery for nasal polyps? [No further questions.]	Yes	No
54	Is the requested medication prescribed by or in consultation with an allergist or immunologist? [If no, no further questions.]	Yes	No
55	Is the patient currently receiving the requested medication? [If no, skip to question 60.]	Yes	No
56	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 60.]	Yes	No
57	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 60.]	Yes	No
58	Does the patient have a documented clinical response to therapy as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
59	Will the patient concurrently be receiving the requested medication with any anti-	Yes	No

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	IL4, anti-IL5, or TSLP inhibitor such as Dupixent, Cinqair, Fasenra, or Tezspire? [No further questions.]		
60	Is the patient greater than or equal to 1 year of age? [If no, no further questions.]	Yes	No
61	Does the patient have a baseline immunoglobulin (Ig) E level greater than or equal to 30 IU/mL? [Note: "Baseline" is defined as prior to receiving any Xolair or anti-interleukin-4/13 therapy (that is, Dupixent [dupilumab subcutaneous injection]).] [If no, no further questions.]	Yes	No
62	Does the patient have a documented diagnosis for IgE-mediated food allergy to one or more foods with signs and symptoms of a significant systemic allergic reaction (i.e., hives, swelling, wheezing, hypotension, gastrointestinal symptoms)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
63	Does the patient have a positive skin-prick test with response to one or more foods? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
64	Does the patient have a positive in vitro test (i.e., blood test) for IgE to one or more foods? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
65	Will the requested medication be used in conjunction with food allergen avoidance?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

If you have any questions, call: 1-888-258-8250

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FAX COMPLETED FORM TO: 1-833-896-0656

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 authorization as per Plan policy and procedures.

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