XOLAIR (OMALIZUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/9/2023)

AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:		DOB:
Street address:	Apt. #:	City/state/zip:		

PRESCRIBER INFORMATION

Prescriber name:		Specialty:	
State license #:	NPI:	MA Provider ID #	
Street address:	Suite #:	City/state/zip:	
Phone:	Fax:		

CLINICAL INFORMATION

Medication requested: ☐ Xolair 150 mg/ml syringe ☐ Xolair 150 mg vial ☐ Xolair 75 mg/0.5 ml syringe ☐ Xolair _____

Dose/directions:	Quantity:	Duration: months
Diagnosis:	Dx code *(required)*:	Weight: lbs / kg

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication, if applicable):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) INFORMATION (if applicable):

Treatment setting: ☐ Infusion Center ☐ Home ☐ Provider's Office ☐ Hospital Outpatient Facility		
Facility name:	Facility NPI:	
J-code:	Number of units:	Date of service (MM/DD/YYYY):

INITIAL REQUESTS

1. Is Xolair being prescribed by or in consultation with a specialist? ☐ Yes – *Provide specialty:*_____ ☐ No
2. <u>For a diagnosis of asthma</u>: Is the patient being treated for moderate to severe allergen-induced asthma (allergic asthma confirmed by either a positive skin test or radioallergosorbent test) to an unavoidable perennial aeroallergen (e.g., pollen, mold, dust mite, etc.)? ☐ Yes – *Submit documentation, including results of allergen reactivity test.* ☐ No
3. <u>For a diagnosis of asthma:</u> Will Xolair be used in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)?
   ☐ Yes – List medications being used: _____
   ☐ No
4. <u>For a diagnosis of chronic idiopathic urticaria (CIU):</u> Does the patient have a history of urticaria for a period of ≥ 6 weeks? ☐ Yes – *Submit documentation.* ☐ No
5. <u>For a diagnosis of CIU:</u> Does the patient require the use of systemic steroids to control urticarial symptoms? ☐ Yes – *Submit documentation.* ☐ No
6. <u>For a diagnosis of CIU:</u> Does the patient have a history of trial and failure, contraindication, or intolerance to an H1 antihistamine taken for at least 2 weeks? Check all that apply.
   ☐ Yes ☐ No
   List medications tried or explain contraindication:_____

RENEWAL REQUESTS

1. <u>For a diagnosis of asthma,</u> has the patient experienced measurable evidence of improvement in asthma severity? ☐ Yes ☐ No
2. For a diagnosis of asthma, will Xolair continue to be used in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)?
   ☐ Yes – List medications being used: _____
   ☐ No
3. Is Xolair being prescribed by or in consultation with a specialist?
   ☐ Yes – Provide specialty: _____
   ☐ No
4. <u>For a diagnosis of chronic idiopathic urticaria,</u> does the patient have documentation of improvement in symptoms and rationale for continued use of Xolair? ☐ Yes ☐ No
   Provide rationale for continued use:

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: