PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

10/17/2025

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Xolair - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Xolair - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Xolair (omalizumab)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for acute bronchospasm or status asthmaticus? Y N

[If yes, no further questions.]

2. Will the requested medication be used for emergency treatment of allergic reactions, including anaphylaxis?	Y N	
[If yes, no further questions.]		
3. Will the requested medication be used for any form of urticaria other than chronic spontaneous urticaria (CSU)?	Y N	
[If yes, no further questions.]		
4. Will Xolair be used for immune checkpoint inhibitor-related toxicities?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 29.]		
5. Does the patient have a documented diagnosis of systemic mastocytosis?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 30.]		
6. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N	
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.		
[If yes, skip to question 44.]		
7. Does the patient have a documented diagnosis of moderate to severe persistent asthma?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 15.]		
8. Is the patient 6 years of age or older?	Y N	
[If no, no further questions.]		
9. Does the patient have a positive skin test or in vitro reactivity to at least one perennial aeroallergen?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
10. Does the patient have a pre-treatment IgE level greater than or equal to 30 IU/mL?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
11. Does the patient have uncontrolled asthma as demonstrated by experiencing at least ONE of the following within the past year: a) 2 or more asthma exacerbations requiring oral or injectable corticosteroid treatment, b) 1 or more asthma exacerbations resulting in hospitalization or emergency medical care visit, or c) poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma)?	Y N	
NOTE: Submission of medical records is required.		

[If no, no further questions.]		
12. Does the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) medium-to-high-dose inhaled corticosteroid, and b) additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
13. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Xolair?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. Will the patient use Xolair concurrently with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Ducala, Tezspire)?	Y N	
[No further questions.]		
15. Does the patient have a documented diagnosis of chronic spontaneous urticaria (CSU)?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 20.]		
16. Is the patient 12 years of age or older?	Y N	
[If no, no further questions.]		
17. Does the patient remain symptomatic despite treatment with up-dosing (at least up to 2x the standard dose) of a second-generation H1 antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine) for at least 2 weeks?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
18. Has the patient been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
19. Has the patient experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		
20. Will Xolair be used for add-on maintenance treatment for nasal polyps?	Y N	
NOTE: Submission of medical records is required.		

[If no, skip to question 37.]		
21. Is the patient 18 years of age or older?	Y N	
[If no, no further questions.]		
22. Does the patient have bilateral nasal polyps and chronic symptoms of sinusitis despite intranasal corticosteroid treatment for at least 2 months?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 24.]		
23. Is intranasal corticosteroid treatment contraindicated or not tolerated?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
24. Does the patient have one of the following: a) a bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril, b) Meltzer Clinical Score of 2 or higher in both nostrils, or c) a total endoscopic nasal polyp score (NPS) of at least 5 with a minimum score of 2 for each nostril?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
25. Does the patient have nasal blockage plus one of the following additional symptoms: a) rhinorrhea (anterior/posterior), b) reduction or loss of smell, or c) facial pain or pressure?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
26. Will the patient continue to use a daily intranasal corticosteroid while being treated with Xolair?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 28.]		
27. Is intranasal corticosteroid contraindicated or not tolerated?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
28. Will the patient use Xolair concurrently with other biologics indicated for nasal polyps (e.g., Dupixent, Nucala)?	Y N	
[No further questions.]		
29. Does the patient have a refractory case of immune therapy related severe (G3) pruritus and elevated IgE levels?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		

30. Is there presence of the major diagnostic criterion for systemic mastocytosis [Major criteria: multifocal, dense infiltrates of mast cells (at least 15 mast cells in aggregates) detected in sections of bone marrow and/or other extracutaneous organs]?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 32.]		
31. Is there presence of at least one of the following minor diagnostic criterion for systemic mastocytosis: a) In biopsy sections of bone marrow or other extracutaneous organs, greater than 25% of mast cells in the infiltrate are spindle-shaped or have atypical morphology, or greater than 25% of all mast cells in bone marrow aspirate smears are immature or atypical, b) Detection of an activating point mutation at codon 816 at KIT in the bone marrow, blood, or another extracutaneous organ, c) Mast cells in bone marrow, blood, o rother extracutaneous organs express CD25 , with or without CD2, in addition to normal mast cell markers, or d) Serum total tryptase persistently greater than 20 ng/mL (unless there is an associated myeloid neoplasm, in which case this parameter is not valid)?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 33.]		
32. Is there presence of 3 or more minor diagnostic criterion for systemic mastocytosis: a) In biopsy sections of bone marrow or other extracutaneous organs, greater than 25% of mast cells in the infiltrate are spindle-shaped or have atypical morphology, or greater than 25% of all mast cells in bone marrow aspirate smears are immature or atypical, b) Detection of an activating point mutation at codon 816 at KIT in the bone marrow, blood, or another extracutaneous organ, c) Mast cells in bone marrow, blood, o rother extracutaneous organs express CD25 , with or without CD2, in addition to normal mast cell markers, or d) Serum total tryptase persistently greater than 20 ng/mL (unless there is an associated myeloid neoplasm, in which case this parameter is not valid)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
33. Will Xolair be used as stepwise prophylactic treatment for chronic mast cell mediator-related cardiovascular and pulmonary symptoms when both of the following have been tried: a) H1 blockers and H2 blockers, and b) Corticosteroids?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
34. Will Xolair be used for prevention of recurrent unprovoked anaphylaxis?	Y N	

NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
35. Will Xolair be used for prevention of hymenoptera or food-induced anaphylaxis, with negative specific IgE or negative skin test?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
36. Will Xolair be used to improve tolerability of venom immunotherapy?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		
37. Does the patient have a documented diagnosis of Immunoglobulin- E (IgE) mediated food allergy?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
38. Is the patient 1 year of age or older?	Y N	
[If no, no further questions.]		
39. Has diagnosis of IgE-mediated food allergy been confirmed by either of the following: a) Pre-treatment allergen-specific IgE level greater than or equal to 6 IU/mL, or b) Skin-prick test with wheal diameter greater than or equal to 4 mm?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
40. Has the patient had a positive physician-controlled oral food challenge, evidenced by any of the following: moderate to severe skin, respiratory, or gastrointestinal symptoms?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 42.]		
41. Does the patient have a history of a systemic reaction to a food?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
42. Does the patient have a pre-treatment serum IgE level greater than or equal to 30 IU/mL?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
43. Will the patient follow a food-allergen avoidance diet?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		

44. Does the patient have a documented diagnosis of asthma?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 48.]		
45. Has asthma control improved on Xolair treatment as demonstrated by at least one of the following: a) A reduction in the frequency and/or severity of symptoms and exacerbations, or b) A reduction in the daily maintenance oral corticosteroid dose?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
46. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroids, additional controller) in combination with Xolair?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
47. Will the patient use Xolair concurrently with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Tezspire, Nucala)?	Y N	
[No further questions.]		
48. Does the patient have a documented diagnosis of chronic spontaneous urticaria?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 50.]		
49. Has the patient experienced a response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		
50. Does the patient have a documented diagnosis of nasal polyps?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 53.]		
51. Has the patient experienced a response as evidenced by improvement in signs and symptoms (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
52. Will Xolair be used concurrently with other biologics indicated for nasal polyps (e.g., Dupixent, Nucala)?	Y N	
NOTE: Submission of medical records is required.		

[No further questions.]	
53. Does the patient have a documented diagnosis of IgE-mediated food allergy?	Y N
NOTE: Submission of medical records is required	
[If no, no further questions.]	
54. Has the patient achieved or maintained a positive clinical response to therapy, evidenced by a decrease in hypersensitivity symptoms?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
55. Will the patient continue to maintain a food-allergen avoidance diet?	Y N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date