Xolair

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: _______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

<u>Drug Information:</u>
*Strength/Measure*_______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*__________________________________ *Route of administration*________________________
*Dosing frequency*________________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Xolair SGM – 07/2021.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
   ❑ Asthma
   ❑ Chronic idiopathic urticaria (CIU)
   ❑ Nasal polyps
   ❑ Other ____

2. What is the ICD-10 code? _________________

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Asthma

3. Will the patient receive Xolair as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? ❑ Yes ❑ No

4. Will the patient receive Xolair concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Nucala)?
   ❑ Yes ❑ No

5. Is the request for continuation of therapy with Xolair? ❑ Yes ❑ No *If No, skip to #8*

6. Is the patient currently receiving Xolair through samples or a manufacturer's patient assistance program?
   If Yes or Unknown, skip to #9 ❑ Yes ❑ No ❑ Unknown

7. Has the patient's asthma control improved on Xolair therapy as demonstrated by at least one of the following?
   Indicate below and no further questions.
   ❑ A reduction in the frequency or severity of symptoms and exacerbations
   ❑ A reduction in the daily maintenance oral corticosteroid dose
   ❑ None of the above

8. Does the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses?
   ❑ Yes ❑ No *Skip to #10*
   a) Inhaled corticosteroid
   b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)
9. Prior to receiving Xolair, did the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses?
   ❑ Yes ❑ No
   a) Inhaled corticosteroid
   b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)

10. Does the patient have positive skin test or *in vitro* reactivity to at least 1 perennial aeroallergen? ❑ Yes ❑ No

11. What is the patient's pre-treatment IgE level? ***ACTION REQUIRED: Please attach chart notes or medical record showing pre-treatment IgE level.*** _________________ IU/mL ❑ No pre-treatment IgE level

Section B: Chronic Idiopathic Urticaria (CIU)

12. Is the request for continuation of therapy with Xolair? ❑ Yes ❑ No *If No, skip to #15*

13. Is the patient currently receiving Xolair through samples or a manufacturer's patient assistance program?
    If Yes or Unknown, skip to #15 ❑ Yes ❑ No ❑ Unknown

14. Has the patient experienced a positive clinical response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy? ❑ Yes ❑ No *No further questions.*

15. How long has the patient had a spontaneous onset wheals and/or angioedema? _________________ weeks

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16. Does the patient remain symptomatic despite treatment with a second-generation H1 antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine) for at least 2 weeks? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) documenting an inadequate symptomatic relief after at least 2 weeks of treatment with a second-generation H1 antihistamine.*** ❑ Yes ❑ No

17. 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)? ❑ Yes ❑ No

Section C: Nasal Polyps

18. Is the request for continuation of therapy with Xolair? ❑ Yes ❑ No *If No, skip to #21*

19. Is the patient currently receiving Xolair through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #21* ❑ Yes ❑ No ❑ Unknown

20. 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, post-nasal drip)? ❑ Yes ❑ No *No further questions.*

21. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis? ❑ Yes ❑ No

22. Has the patient had intranasal corticosteroid treatment for at least 2 months? *If Yes, skip to #24* ❑ Yes ❑ No

23. Are intranasal corticosteroids contraindicated or not tolerated? ❑ Yes ❑ No

24. Has the patient had a bilateral nasal endoscopy or anterior rhinoscopy showing polys reaching below the lower border of the middle turbinate or beyond in each nostril? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record showing endoscopy or rhinoscopy details (e.g., polyps location, size).*** ❑ Yes ❑ No

25. Does the patient have nasal blockage? ❑ Yes ❑ No

26. Does the patient have rhinorrhea (anterior/posterior) or reduction or loss of smell? ❑ Yes ❑ No

27. Will the patient be using a daily intranasal corticosteroid while being treated with Xolair? *If Yes, no further questions* ❑ Yes ❑ No

28. Are intranasal corticosteroids contraindicated or not tolerated? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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