

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Xolair® (omalizumab): Prior Authorization Request Form: Please respond.

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- Please complete the attached Xolair® (omalizumab) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Xolair® (omalizumab)**

The third expert panel asthma guidelines suggests that Xolair® may be considered as adjunctive therapy for patients who have allergies and severe persistent asthma that is inadequately controlled with a long acting beta-agonist and high-dose inhaled corticosteroids. Anaphylaxis, presenting as bronchospasm, hypotension, syncope, urticaria, and/or angioedema of the throat or tongue, has been reported to occur after administration of omalizumab. Anaphylaxis has occurred as early as after the first dose of omalizumab, but also has occurred beyond 1 year after beginning regularly administered treatment.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

# Prior Authorization Request Form

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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Xolair® (omalizumab) Criteria

- 1 Please indicate Xolair®'s dispensing location:  
 from the pharmacy  
 from the physician's supply, incident to a physician's service  
 Other: \_\_\_\_\_
- 2 Please specify diagnosis for required agent. Select or indicate the correct ICD-9 code. **This question must be completed.**  
 Allergic asthma (moderate to severe) (ICD-9:493)  
 Other (diagnosis and ICD-9 code): \_\_\_\_\_
- 3 Has the patient demonstrated an IgE level > or =30 but < or = 700 IU/ml AND Positive skin test or in vitro reactivity to a perennial aeroallergen?  
 Yes  No
- 4 Is the prescribing physician an allergist or pulmonologist?  
 Yes  No
- 5 Does the patient have a history of hypersensitivity to Xolair®?  
 Yes  No
- 6 Does the patient have symptoms that are inadequately controlled despite optimal use of a high dose of inhaled corticosteroids with combination therapy (long acting B2 agonist) for at least three months OR can not tolerate systemic corticosteroids to maintain adequate control?  
 Yes  No
- 7 Has the patient been compliant with their asthma medications?  
 Yes  No
- 8 Has the patient required frequent utilization of health care resources documented by at least three outpatient/ emergency room visits annually and/or asthma exacerbation requiring ICU admission?  
 Yes  No
- 9 Will Xolair® be administered under direct medical supervision to monitor for potential anaphylaxis?  
 Yes  No

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_