univera HEALTHCARE

Specialty Medication Review Program

Xolair® (omalizumab)
(Health Professional Administered)
OR (Self-Administered)
Rx & Medical Benefit

Complete this form and fax to:

☐ **Medical (Office Admin)**
Fax: 1-800-306-0188
Phone: 1-800-499-1275

If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

☐ Pharmacy **(Self-admin)**
Fax: 1-800-956-2397
Phone: 1-800-499-1275

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone: 1-866-413-4137

☐ **Walgreens Specialty Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #:	Patient Birthdate:
List Patient Allergy (If Any):	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ **Prescriber office** ☐ **Home/Homecare agency:**_____
☐ **Outpatient facility** ☐ **Other:** _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

Medication (HCPCS)	Form	Dose	Frequency	Height	Weight (lbs. or kg)	Procedure Code
Xolair (J2357)	☐ **Vials** ☐ **PFS** ☐ **Autoinjector**					

Diagnosis/ICD-10:

Is this request for a: ☐ New Start ***OR*** ☐ Continuation of Therapy (Recertification) Start date: _____

Is this therapy (CHECK ONE):

XOLAIR PREFILLED SYRINGES (PFS) May be covered under the medical benefit (administered by a healthcare professional) **OR** the pharmacy benefit (self-administered)

XOLAIR VIALS are administered by a healthcare professional only, and are covered under the medical benefit; However, ***select*** benefits may allow for coverage of vials under the pharmacy benefit

☐ **New Start** – First 3 doses to be obtained by patient from a pharmacy and brought to office **(for provider administration and teaching), then ongoing self-administration** (Please fax to the Pharmacy Dept at 1-800-956-2397)

☐ **New Start** – First 3 doses to be obtained by office (buy/bill) and **given under medical benefit, then ongoing self-administration.**
If you are using vials in office, but will change to the PFS for self-administration, please indicate as such by placing an 'X' here: _____
(Please fax to the Pharmacy Dept at 1-800-956-2397)

☐ **New Start** – All doses will be **obtained and administered by a healthcare professional**

☐ **Continuation of Therapy** – **ongoing self-administration** (Please fax to the Pharmacy Dept at 1-800-956-2397)

☐ **Continuation of Therapy** – All doses will be **obtained and administered by a healthcare professional**

****For Self-administration only,** you must attest this patient is an appropriate candidate by checking **ALL boxes:**

☐ The patient has no prior history of anaphylaxis (including to Xolair or other agents)
☐ The patient has or will receive at least 3 doses of Xolair under the supervision of a healthcare provider
☐ The patient/caregiver has been appropriately trained to self-administer Xolair injections
☐ The patient/caregiver has the ability to recognize the symptoms of anaphylaxis
☐ The patient/caregiver has the ability to appropriately treat anaphylaxis

Continue onto the next page

univera HEALTHCARE

Xolair® (omalizumab)
(Health Professional Administered)
OR (Self-Administered)
Rx & Medical Benefit

Questions/Indications for Medical Necessity	
**** See the Xolair Policy (Pharmacy-57) for full Prior Authorization criteria ****	
Select One of The Following Diagnoses:	
☐ Asthma ☐ Urticaria	☐ Nasal Polyps ☐ Other: _____
1. ****Please submit patient progress notes with all requests**. Also, provide detail regarding sample medications given, including date and quantity supplied. For recertification requests, please submit documentation of objective assessment of response to medication (e.g., asthma: reduction in exacerbation frequency. Urticaria: decreased size/number of hives. Nasal polyps: decreased size of nasal polyps, improved breathing/smell).	
2. Is the patient a ☐Smoke ☐Non-Smoker (Non-Smoker defined as not smoked tobacco in the past six (6) months)	☐ **Yes** ☐ **No**
Asthma	
1. What is the patient's baseline IgE level?_____ IU/ml Date: _____	☐ **Yes** ☐ **No**
2. Was aeroallergen skin test completed? Submit copy of test results documenting evidence of at least 1 perennial aeroallergen by skin test (e.g., prick/puncture test) or **blood test (e.g., RAST class 2 or greater)**	☐ **Yes** ☐ **No**
3. Has the patient had at least 2 asthma exacerbations requiring medical intervention within the preceding 12 months? (*Provide progress notes to document the **dates and nature of interventions**)	☐ **Yes** ☐ **No**
☐ unscheduled doctor visits ☐ urgent care visits	☐ documented acute systemic steroids ☐ emergency room visits/hospital admissions
Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)	
1. What is the patient's baseline IgE level?_____ IU/ml Date: _____	
2. Has the patient's condition lasted for at least 12 weeks?	☐ **Yes** ☐ **No**
3. Will Xolair be used with an inhaled nasal steroid. If yes, provide drug name: _____	☐ **Yes** ☐ **No**
4. *Note all previous therapies below and **s**ubmit progress notes demonstrating evidence of nasal polyps ≥12 weeks. (Include details for each course (Ex. Prednisone 40mg daily and taper as directed for 15 days)) and plan for continued therapy with intranasal corticosteroids.	

Nasal & Oral Steroid Use	Strength & Dosing	Period of use	Outcomes
		Start: End:	
		Start: End:	
		Start: End:	

Prior Surgeries	Dates	Outcomes

Urticaria Diagnosis	
1. Has the patient's condition lasted for at least 6 weeks?	☐ **Yes** ☐ **No**
2. Indicate current & previous treatments with progress notes* for this indication	

Drug Name	Strength & Dosing	Period of use	Outcomes
		Start: End:	
		Start: End:	

Food Allergies	
1. What is the patient's baseline IgE level? _____ IU/ml Date: _____	
2. Does the patient have a confirmed diagnosis of an IgE- mediated food allergy? Please provide skin testing or IgE blood testing from the past 12 months to confirm.	☐ **Yes** ☐ **No**
3. Does the patient have documentation of occurrence of significant allergic symptoms (e.g., moderate to severe skin, respiratory or gastrointestinal symptoms, etc.) when exposed to applicable allergens? Please provide documentation.	☐ **Yes** ☐ **No**
4. Will Xolair be used in conjunction with food allergen avoidance?	☐ **Yes** ☐ **No**
Provide Other Comments/Clinical Justification:	

****ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.****

*Prescriber Signature: _____ Date: _____

I certify the above is true and accurate to the best of my knowledge