Print Reset

Xolair (omalizumab)
Choice Prior Authorization Request Prescriber Fax
Fax this form to 888-272-1349

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit web.primetherapeutics.com/provider/forms or primetherapeutics.com/commercial-formularies.

What is the priority level of this request?

- ☐ Standard
- ☐ Date of service (if applicable): _____
- ☐ Urgent (**Note:** Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax:

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

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Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated:

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA FOR ALL REQUESTS

Note: Please attach any additional information that should be considered with this request.

Patient's Diagnosis:

- ☐ Moderate-to-severe persistent asthma
- ☐ Chronic spontaneous urticaria (CSU)
- ☐ Chronic rhinosinusitis with nasal polyposis (CRSwNP)
- ☐ IgE-mediated food allergy
- ☐ Other (ICD 10 and description below):

  ICD code: _____

  ICD description: _____

1. Is the patient currently being treated with the requested agent?
   ☐ Yes ☐ No
2. Has the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days?
   ☐ Yes ☐ No

   If Yes, is the patient at risk if therapy is changed?
   ☐ Yes ☐ No

   If Yes, please explain risk:

   _____
3. What is the patient's weight (in kg)? _____ kg
4. What is the patient's pretreatment IgE level?_____(IU/mL)
5. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pulmonologist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis?
   ☐ Yes ☐ No

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Patient's Name (Last, First): _____

6. Does the patient have any FDA-labeled contraindications to the requested agent?
   ☐ Yes ☐ No

   If Yes, please specify FDA-labeled contraindications:

   _____

7. Is the patient an adult?
   ☐ Yes ☐ No

   If No, is the patient's age within FDA labeling for the requested indication for the requested agent?
   ☐ Yes ☐ No

   If No, is there information in support of using the requested agent for the patient's age for the requested indication?
   ☐ Yes ☐ No

   If Yes, please provide supporting information:

   _____

8. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors)?
   ☐ Yes ☐ No

   If Yes, please specify the agent to be used concomitantly:

   _____

   If Yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent?
   ☐ Yes ☐ No

   If No, is there information in support of combination therapy (submitted copy required, e.g., clinical trials, phase III studies, guidelines required)? **If Yes,** submit supporting information.
   ☐ Yes ☐ No

9. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindication, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max).

   _____

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Patient's Name (Last, First): _____

10. Please list all medications that the patient has previously tried and had an inadequate response, intolerance or contraindication to for the treatment of this diagnosis. Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.

    Medication: _____

    Outcome of trial: _____

    Date (from): _____ Date (to): _____

    Medication: _____

    Outcome of trial: _____

    Date (from): _____ Date (to): _____

    Medication: _____

    Outcome of trial: _____

    Date (from): _____ Date (to): _____

CRITERIA FOR MODERATE-TO-SEVERE PERSISTENT ASTHMA

11. What is the patient's pretreatment serum IgE level? _____ IU/mL
12. What is the patient's weight (in kg)? _____ kg
13. Has allergic asthma been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen?
    ☐ Yes ☐ No
14. Does the patient have a history of uncontrolled asthma while on asthma control therapy (e.g., inhaled corticosteroid [ICS]/long-acting beta-2 agonist [LABA] combination therapy)?
    ☐ Yes ☐ No

    If Yes, how is that uncontrolled asthma demonstrated? (Select all that apply.)
    ☐ Two or more severe asthma exacerbations (i.e. required treatment with a systemic corticosteroid [steroid burst]) within the past 12 months
    ☐ One or more serious asthma exacerbations (i.e., required hospitalization, mechanical ventilation, or visit to the emergency room or urgent care) within the past 12 months
    ☐ Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered
    ☐ Baseline Forced Expiratory Volume (FEV_1) that is less than 80% of predicted
15. Does the patient's medication history indicate use of a biologic immunomodulator agent that is FDA labeled or supported in compendia for the treatment of asthma within the past 12 months (**excluding use of samples**)?
    ☐ Yes ☐ No

    If Yes, please list medication(s) including dates of treatment:

    _____

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Patient's Name (Last, First): _____

16. Is the patient currently being treated with a biologic immunomodulator agent that is FDA labeled or supported in compendia for the treatment of asthma (including the requested agent)?

☐ Yes ☐ No

17. If the patient is currently on the requested agent, is the patient currently treated with an inhaled corticosteroid for at least 3 months that is **adequately dosed to control symptoms**?

☐ Yes ☐ No

If Yes, has the patient been adherent for 90 days within the past 120 days?

☐ Yes ☐ No

If Yes, please specify:

_____

18. Is the patient currently treated with a **maximally tolerated** inhaled corticosteroid for at least 3 months?

☐ Yes ☐ No

If Yes, has the patient been adherent for 90 days within the past 120 days?

☐ Yes ☐ No

If Yes, please specify:

_____

If No, does the patient have an intolerance or hypersensitivity to inhaled corticosteroid therapy?

☐ Yes ☐ No

If Yes, please explain intolerance/hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to all inhaled corticosteroids?

☐ Yes ☐ No

If Yes, please specify FDA-labeled contraindication:

_____

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Patient's Name (Last, First): _____

19. Is the patient currently being treated for at least 3 months with a long-acting beta-2 agonist (LABA), a leukotriene receptor antagonist (LTRA), a long-acting muscarinic antagonist (LAMA), and/or theophylline?

☐ Yes ☐ No

If Yes, has the patient been adherent for 90 days within the past 120 days?

☐ Yes ☐ No

If Yes, please specify:

_____

If No, does the patient have an intolerance or hypersensitivity to therapy with **one** LABA, a LTRA, a LAMA, or theophylline?

☐ Yes ☐ No

If Yes, please specify therapy and explain intolerance/hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to **all** LABA, LTRA, LAMA, and theophylline?

☐ Yes ☐ No

If Yes, please specify FDA-labeled contraindication:

_____

20. Will the patient continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent?

☐ Yes ☐ No

CRITERIA FOR CHRONIC SPONTANEOUS URTICARIA (CSU)

21. Has the patient had hives and itching for more than 6 weeks?

☐ Yes ☐ No

22. In order to reduce urticaria risk, has the prescriber evaluated the patient to determine if the patient is currently treated with medication known to cause or worsen urticaria (e.g., NSAIDs)?

☐ Yes ☐ No

23. Has patient tried and had an inadequate response to the FDA labeled maximum dose of **one** second-generation H1-antihistamine (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)?

☐ Yes ☐ No

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Patient's Name (Last, First): _____

24. Has the patient tried and had an inadequate response to a maximally tolerated dose of **one** second-generation H1-antihistamine titrated up to 4 times above the FDA labeled maximum dose after at least a 2-week duration of therapy?

☐ Yes ☐ No

If No, please provide support showing that the patient cannot be treated with a second-generation H1- antihistamine at a dose above the FDA labeled maximum dose:

_____

25. Does the patient have an intolerance or hypersensitivity to **one** second-generation H1-antihistamine therapy?

☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to **all** second-generation H1-antihistamines?

☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

26. Is the patient **currently** being treated with second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)?

☐ Yes ☐ No

If Yes, will the patient continue taking the second-generation H1-antihistamine therapy in combination with the requested agent?

☐ Yes ☐ No

If No, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to **all** second-generation H1-antihistamines?

☐ Yes ☐ No

If Yes, please explain:

_____

CRITERIA FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)

27. What is the patient's pretreatment serum IgE level? _____ IU/mL

28. What is the patient's weight (in kg)? _____ kg

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Patient's Name (Last, First): _____

30. Does the patient have symptoms consistent with chronic rhinosinusitis (CRS)?
    ☐ Yes ☐ No

    If Yes, how is the patient's CRS demonstrated? (Select all that apply.)
    ☐ Nasal discharge (rhinorrhea or post-nasal drainage)
    ☐ Nasal obstruction or congestion
    ☐ Loss or decreased sense of smell (hyposmia)
    ☐ Facial pressure or pain

31. Has the patient had symptoms consistent with CRS for at least 12 consecutive weeks?
    ☐ Yes ☐ No

32. Is there information indicating the patient's diagnosis was confirmed by one of the following: (1) anterior rhinoscopy, (2) nasal endoscopy, or (3) computed tomography (CT) of the sinuses?
    ☐ Yes ☐ No

33. Has the patient tried and had an inadequate response to **one** intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) after at least a 4-week duration of therapy?
    ☐ Yes ☐ No

    If Yes, specify:

    _____

    If No, does the patient have an intolerance or hypersensitivity to **one** intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva)?
    ☐ Yes ☐ No

    If Yes, please explain the patient's intolerance or hypersensitivity:

    _____

    If No, does the patient have an FDA-labeled contraindication to **all** intranasal corticosteroids?
    ☐ Yes ☐ No

    If Yes, please specify the patient's FDA-labeled contraindication:

    _____

34. Is the patient currently treated with standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva])?
    ☐ Yes ☐ No

35. Will the patient continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent?
    ☐ Yes ☐ No

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Patient's Name (Last, First): _____

CRITERIA FOR IgE-MEDIATED FOOD ALLERGY

36. What is the patient's pretreatment serum IgE level? _____ IU/mL
37. What is the patient's weight (in kg)? _____ kg
38. Has the patient's IgE-mediated food allergy been confirmed by an allergy diagnostic test (e.g., skin prick test, serum specific IgE test, oral food challenge)?
    ☐ Yes ☐ No
39. Will the patient avoid known food allergens while treated with the requested agent?
    ☐ Yes ☐ No
40. Will the requested agent be used for emergency treatment of allergic reactions, including anaphylaxis?
    ☐ Yes ☐ No
41. Does the patient have epinephrine on hand for emergency treatment?
    ☐ Yes ☐ No

RENEWAL CRITERIA FOR ALL REQUESTS

42. Has the patient had clinical benefit with the requested agent?
    ☐ Yes ☐ No

RENEWAL CRITERIA FOR MODERATE-TO-SEVERE PERSISTENT ASTHMA

43. Is the patient currently treated within the past 90 days and compliant with asthma control therapy (i.e., inhaled corticosteroids [ICS], ICS/ long-acting beta-2 agonist [ICS/LABA], leukotriene receptor antagonist [LTRA], long-acting muscarinic antagonist [LAMA], theophylline)?
    ☐ Yes ☐ No

RENEWAL CRITERIA FOR CHRONIC SPONTANEOUS URTICARIA (CSU)

44. Will the patient continue second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) in combination with the requested agent?
    ☐ Yes ☐ No

    If No, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to **all** second-generation H1-antihistamines?

    ☐ Yes ☐ No

    If Yes, specify:

    _____

RENEWAL CRITERIA FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)

45. Will the patient continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent?
    ☐ Yes ☐ No

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Patient's Name (Last, First): _____

RENEWAL CRITERIA FOR IgE-MEDIATED FOOD ALLERGY

46. Will the patient avoid known food allergens while treated with the requested agent?
    ☐ Yes ☐ No
47. Does the patient have epinephrine on hand for emergency treatment?
    ☐ Yes ☐ No

☐ Attachments

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 1-800-651-8921

Fax this form to 888-272-1349

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