**OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.**
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Xolair® Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

## Member Information (required)

| | | |
|---|---|---|
| Member Name: | | |
| Insurance ID#: | | |
| Date of Birth: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | | |

## Provider Information (required)

| | | |
|---|---|---|
| Provider Name: | | |
| NPI#: | Specialty: | |
| Office Phone: | | |
| Office Fax: | | |
| Office Street Address: | | |
| City: | State: | Zip: |

## Medication Information (required)

| | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis:**

❑ Chronic idiopathic urticaria
❑ Moderate to severe persistent uncontrolled allergic asthma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

**For moderate to severe persistent uncontrolled allergic asthma, answer the following:**

Select if the patient has moderate to severe persistent uncontrolled allergic asthma as defined by the following:

- ❑ Daily asthmatic symptoms
- ❑ Daily use of inhaled short-acting beta2-agonist
- ❑ Exacerbations that affect/limit activity
- ❑ Exacerbations (requiring oral systemic corticosteroids) greater than or equal to 2 times a year
- ❑ Nighttime awakenings more than once a week
- ❑ Forced expiratory volume in one second (FEV1) or peak expiratory flow (PEF) less than or equal to 80% of predicted level
- ❑ Measures of asthma control indicate uncontrolled asthma (e.g., Asthma Control Test [ACT] score ≤ 19)

Document the baseline (pre-Xolair treatment) serum total IgE level: _____ IU/mL

Does the patient have a positive skin test or in vitro reactivity to perennial aeroallergen? ❑ **Yes** ❑ **No**

Are symptoms adequately controlled on a high-dose inhaled corticosteroid **AND** a long-acting beta2-agonist combination for at least 3 months unless there is contraindication or intolerance to these therapies? ❑ **Yes** ❑ **No**

Select if the patient has documented failure (e.g., emergency room visit or hospitalization for asthma exacerbation, need for oral steroid burst) of at least 3 months to regular/routine treatment with the following treatment(s):

- ❑ Combination inhaled corticosteroid / long-acting beta2-agonist product [e.g., Advair (fluticasone / salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]
- ❑ Inhaled corticosteroid at maximum dosage [e.g., Flovent (fluticasone propionate), Pulmicort (budesonide), QVAR (beclomethasone dipropionate)]
- ❑ Long-acting beta2-agonist [e.g., Foradil (formoterol fumarate), Serevent (salmeterol xinafoate)]

Is Xolair prescribed by or in consultation with an allergist, immunologist, or pulmonologist? ❑ **Yes** ❑ **No**

**Reauthorization:**

Is there documentation the patient has had a positive clinical response to Xolair therapy? ❑ **Yes** ❑ **No**

Does the patient have a reduction in the number of asthma exacerbations from baseline (e.g., asthma exacerbation requiring treatment with systemic corticosteroids or doubling of inhaled corticosteroid [ICS] dose from baseline)? ❑ **Yes** ❑ **No**

Does the patient have improvement in forced expiratory volume in 1 second (FEV1) from baseline? ❑ **Yes** ❑ **No**

Has the patient had decreased use of rescue medications from baseline? ❑ **Yes** ❑ **No**

# Xolair® Prior Authorization Request Form (Page 2 of 2)

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**For chronic idiopathic urticaria, answer the following:**

Select if the patient remains symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to the following:

- ❑ **Two** H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]
- ❑ **One** second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)] taken in combination with the following:
  - ❑ A different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]
  - ❑ First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Clor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]
  - ❑ H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]
  - ❑ Leukotriene modifier [e.g., Accolate (zafirlukast), Singulair (montelukast), Zyflo (zileuton)]

Does the patient have persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1-antihistamine, unless there is a contraindication or intolerance to H1 antihistamines? ❑ **Yes** ❑ **No**

If "yes" to the above question, select if the patient has tried and had inadequate response or intolerance to the following additional therapies:

- ❑ Doxepin
- ❑ H1 antihistamine
- ❑ H2 antagonist
- ❑ Hydroxyzine
- ❑ Leukotriene receptor antagonist

Will Xolair be used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines? ❑ **Yes** ❑ **No**

Is Xolair prescribed by or in consultation with an allergist, immunologist, or dermatologist? ❑ **Yes** ❑ **No**

**Reauthorization:**

Is there documentation the patient has had a positive clinical response to Xolair therapy? ❑ **Yes** ❑ **No**

Has the patient's disease status been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment? ❑ **Yes** ❑ **No**

Select if the patient has experienced the following:

- ❑ Reduction in itching severity from baseline
- ❑ Reduction in the number of hives from baseline

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.