

Xolair

Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information

2. Physician information

Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

Xolair			Specify:
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7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Initial request	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the client have a diagnosis of moderate to severe persistent asthma in the last 730 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client had a positive skin test or in vitro reactivity to a perennial aeroallergen in the last 5 years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the client have at least 60 days therapy with an inhaled corticosteroid (ICS) in the last 90 days OR does the client have an intolerance, hypersensitivity, or contraindication to inhaled corticosteroids?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the client have at least 60 days therapy with a long-acting beta agonist (LABA), leukotriene modifier (LTM), long-acting muscarinic antagonist (LAMA) or theophylline in the last 90 days OR does the client have an intolerance or hypersensitivity to all classes listed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the client's pretreatment IgE level ≥ 30 IU/mL and ≤ 700 IU/mL (12 years and older) OR ≥ 30 IU/mL and ≤ 1300 IU/mL (6 to < 12 years of age)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the client weigh more than 150kg?

provider.wellpoint.com/tx/

Wellpoint members in the Medicaid Rural Service Area and the STAR Kids program are served by Wellpoint Insurance Company; all other Wellpoint members in Texas are served by Wellpoint Texas, Inc.

- Yes No Is the requested dose (based on the client's pretreatment serum IgE level and body weight) equal to the dose defined in the FDA labeling, not to exceed 375 mg every 2 weeks?
- Yes No Does the client have a diagnosis of chronic spontaneous urticaria (CSU) in the last 730 days?
- Yes No Does the client have at least 60 days therapy with an H1 antihistamine in the last 90 days OR is does the client have an intolerance, hypersensitivity, or contraindication to all H1 antihistamines?
- Yes No Does the client have a diagnosis of nasal polyps in the last 730 days?
- Yes No Does the client have at least 90 days therapy with an intranasal corticosteroid (INC) in the last 120 days OR does the client have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?
- Yes No Is the client's pretreatment IgE level ≥ 30 IU/mL and ≤ 1500 IU/mL?
- Yes No Will the client have concurrent therapy with another monoclonal antibody agent indicated for the treatment of asthma, chronic spontaneous urticaria or nasal polyps?

Renewal request

- Yes No Does the client have a diagnosis of moderate to severe persistent asthma in the last 730 days?
- Yes No Does the client have current therapy with an inhaled corticosteroid that will continue during therapy with Xolair OR does the client have an intolerance, hypersensitivity, or contraindication to inhaled corticosteroids?
- Yes No Does the client weigh more than 150kg?
- Yes No Does the client have a diagnosis of chronic spontaneous urticaria in the last 730 days?
- Yes No Does the client have a diagnosis of nasal polyps in the last 730 days?
- Yes No Does the client have current therapy with an intranasal corticosteroid that will continue during therapy with Xolair OR does the client have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?
- Yes No Does the client weigh more than 150kg?
- Yes No Will the client have concurrent therapy with another monoclonal antibody agent indicated for the treatment of asthma, chronic spontaneous urticaria or nasal polyps?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/formulary-search>

9. Physician signature

Prescriber or authorized signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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