

Neighborhood Health Plan of Rhode Island Prior Authorization Form Xolair® (Omalizumab)

If approval criteria are met Neighborhood Health Plan of Rhode Island will authorize coverage of Xolair® (Omalizumab). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance. Fax Number **866-423-0945**.

PLEASE COMPLETE THE FOLLOWING Omalizumab SECTIONS:

Patient Name: _____ Member ID# : _____ Date of Request: ___/___/___

Date of Birth: ___/___/___ Pt. Weight in kg: _____

Provider Name: _____ Phone: _____ Fax: _____

INDICATIONS FOR USE: *(if this is a renewal proceed to question 10)*

	YES	NO
1. Patient is diagnosed with: --Severe persistent asthma (daily symptoms, nighttime symptoms >1 time/wk, PEF or FEV ₁ >60%-<80%, PEF variability >30%)	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is being followed by a specialist (Allergist/Pulmonologist)	<input type="checkbox"/>	<input type="checkbox"/>
3. Allergic asthma has been established by skin or blood test for sensitivity to a perennial aeroallergen	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient is ≥ 12 years of age	<input type="checkbox"/>	<input type="checkbox"/>
5. Patient is receiving first line maintenance therapies according to NIH recommendations based on severity: high dose inhaled corticosteroids and a long acting beta ₂ -agonist for at least 6 months and must be consistently filled for 6 months prior to Xolair request.	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient has been actively involved with Neighborhood case management/disease management for ≥ 3 months	<input type="checkbox"/>	<input type="checkbox"/>
7. Patient must not be smoking for at least 6 months	<input type="checkbox"/>	<input type="checkbox"/>
8. Patient has had inadequate response (utilization of emergency department, hospitalization, or urgent care visits, or excessive use of short-acting beta ₂ -agonist/oral steroids, or has had impairment in ADLs) OR has developed intolerable side effects to adequate doses of maintenance therapy	<input type="checkbox"/>	<input type="checkbox"/>
9. Baseline IgE level ≥ 30 IU/mL and ≤ 700 IU/mL	<input type="checkbox"/>	<input type="checkbox"/>
10. Weight ≤ 150kg	<input type="checkbox"/>	<input type="checkbox"/>
11. Severity of asthma is such that the benefit of Xolair treatment outweighs the potential risk of anaphylaxis or malignancy	<input type="checkbox"/>	<input type="checkbox"/>
12. If this is a renewal: Has the patient experienced a reduction in asthma exacerbations or been able to decrease their pretreatment steroid dose?	<input type="checkbox"/>	<input type="checkbox"/>
What additional objective evidence has occurred to warrant continued use of Xolair®?		

WARNING

In addition to cases of anaphylaxis occurring within 2 hours of Xolair treatment, **there are new reports of delayed anaphylaxis—with onset up to 24 hours or even longer—after receiving Xolair. This can occur after ANY dose, even if previously tolerated. The FDA recommends that patients should have, and be trained to use, an epinephrine auto-injector. They should also carry medical contact information should an event occur.**

If patient meets criteria:

- **Initial approval: 4 months** • **Quantity limit: 6 vials/30 days** • **Renewal approval period: 8 months**

Prescriber's Signature and NPI

Date