HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
XOLAIR®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-213-1547
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Xolair® (omalizumab)

Dosing/Frequency:_____

Note: for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
ASTHMA			
1. Is the member 6 years of age or older?	☐	☐	
2. Is the prescribing physician an allergist, dermatologist, immunologist, or a pulmonologist?	☐	☐	
3. Has the member shown a positive skin test or in vitro reactivity to a perennial aeroallergen?	☐	☐	**Please provide documentation**
4. Has the member been compliant on a high-dose inhaled corticosteroid with a long-acting inhaled beta-2-agonist for at least 5 months?	☐	☐	
5. Has the member had ≥2 acute exacerbations in a 12-month period requiring additional medical treatment (emergency department visits, hospitalizations, or frequent office visits)?	☐	☐	**Please provide documentation**
6. Does documentation include a current Asthma Control Test?	☐	☐	**Please provide documentation**
7. Are the member's pre-treatment serum IgE levels ≥30 IU/mL and ≤700 IU/mL?	☐	☐	**Please provide documentation**
8. Does documentation include a predicted FEV1 or PEF?	☐	☐	**Please provide documentation**

CHRONIC IDOPATHIC URTICARIA (CIU)			
1. Is the member 12 years of age or older?	☐	☐	
2. Has the provider performed a medical evaluation that rules out other possible causes of urticaria?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure of an H1-antihistamine used in combination with an H2-antihistamine?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of an H1-antihistamine used in combination with a leukotriene receptor antagonist or cyclosporine?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show continued medical necessity and that the treatment has stabilized or improved the member's condition?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy PHARM-079
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