HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM XOLAIR®

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

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

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 Pharmacy Customer Service for assistance at 385-425-5094

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									
Office Phone: Office Phone: Office Fax: Office Contact: Helght/Weight: 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	Disc	claimer: Prior authorization request forms are subject to	change in accord	lance wi	th Fede	ral and State notice requirements.			
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2.	Has the member had a trial and failure of an H1-antihistamine used in combination with an H2-antihistamine?			Please provide documentation			
3.	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			
4.	Is the request for dose escalation of Xolair?						
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:							

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

Policy PHARM-HU-079
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/08/2023
Next Review Date: 11/08/2024

Current Effective Date: 12/01/2023

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