REALRx

PRIOR AUTHORIZATION REQUEST FORM
XOLAIR®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 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 assistance 385-425-5094.

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
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
ASTHMA			
1. Is the prescribing physician an allergist, dermatologist, immunologist, or a pulmonologist?	☐	☐	
2. Has the member shown a positive skin test or in vitro reactivity to a perennial aeroallergen?	☐	☐	**Please provide documentation**
3. Has the member been compliant on a high-dose inhaled corticosteroid with a long-acting inhaled beta-2-agonist for at least 5 months?	☐	☐	
4. 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**
5. Does documentation include a current Asthma Control Test ≤19?	☐	☐	**Please provide documentation**
6. Are the member's pre-treatment serum IgE levels ≥30 IU/mL and ≤700 IU/mL?	☐	☐	**Please provide documentation**

7. Does documentation include a predicted FEV1 or PEF?	☐	☐	**Please provide documentation**
CHRONIC IDOPATHIC URTICARIA (CIU)			
1. Has the provider performed a medical evaluation that rules out other possible causes of urticaria?	☐	☐	**Please provide documentation**
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?	☐	☐	
IgE-Mediated Food Allergy			
1. Is the prescribing physician an allergist or immunologist?	☐	☐	
2. Is the member aged between 1 and 17 years old?	☐	☐	
3. Is baseline immunoglobulin (Ig)E level ≥ 30 IU/mL?	☐	☐	**Please provide documentation**
4. Does documentation show that the member has experienced dose-limiting symptoms (e.g. moderate to severe skin, respiratory, or GI symptoms) to a single dose of ≤100 mg of peanut protein, or ≤300 mg protein for each of 2 of the following other 6 foods: milk, egg, wheat, cashew, hazelnut, or walnut?	☐	☐	**Please provide documentation**
5. Does documentation show a positive skin test (≥4 mm wheal greater than saline control) AND in vitro reactivity (IgE ≥6 kUA/L) to peanut, or at least two of the following 6 other foods: milk, egg, wheat, cashew, hazelnut, walnut?	☐	☐	**Please provide documentation**
6. Does member have an active prescription for an EpiPen?	☐	☐	
7. Does documentation show that Xolair will be used in conjunction with a diet that avoids food allergens?	☐	☐	
8. Does member have a history of severe anaphylaxis, eosinophilic esophagitis, poorly controlled atopic dermatitis, or poorly controlled asthma?	☐	☐	
9. Does documentation show that Xolair® will not be used in combination with other monoclonal antibody therapy, such as Dupixent® (dupilumab), Fasenra™ (benralizumab), Nucala® (mepolizumab), and/or Cinqair® (reslizumab)?	☐	☐	
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
Origination Date: 05/30/2015
Reviewed/Revised Date: 05/22/2024
Next Review Date: 05/22/2025
Current Effective Date: 06/01/2024