SoonerCare
Oklahoma Health Care Authority

Statement of Medical Necessity for Xolair® (Omalizumab): Chronic Idiopathic Urticaria Diagnosis

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN INFORMATION	
Physician Name:	
Address:	
City:	State: Zip:
Phone: ( )	
Fax: ( )	

MEMBER INFORMATION	
Member ID Number:	
Member Name:	
Address:	
City:	State: Zip:
Phone: ( )	

Name of outpatient healthcare facility where Xolair® will be delivered to and administered at:
_____

Compliance with all of the prior authorization criteria is a condition for payment for this drug by OHCA.

All information must be provided and OHCA may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

1. Detailed description of diagnosis: _____
2. Date diagnosed: _____
3. Have other forms of urticaria been ruled out? Yes ☐ No ☐
4. Have other potential causes of urticaria been ruled out? Yes ☐ No ☐
5. Member's Urticaria Activity Score (UAS): _____
6. List medications, dose prescribed, and dates of use for the treatment of this diagnosis:

Drug/Dose/Dates of Use: _____ Drug/Dose/Dates of Use: _____

Drug/Dose/Dates of Use: _____ Drug/Dose/Dates of Use: _____

Drug/Dose/Dates of Use: _____ Drug/Dose/Dates of Use: _____

Drug/Dose/Dates of Use: _____ Drug/Dose/Dates of Use: _____

7. Compliant on above medications for duration of therapy listed? Yes ☐ No ☐
8. Xolair Dose:
   - ❑ 150mg
   - ❑ 300mg *(Not approved for initial dosing)*
9. Prescriber specialty? _____

The above format is to assist the physician in providing medical documentation that OHCA needs to review this request. This information should come directly from the prescriber and NOT the pharmacy provider.

**** Please provide copies of medical documentation supporting the information above.**

Prescriber Signature: _____ Date: _____
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*