State of Oklahoma
Oklahoma Health Care Authority
Xolair® (Omalizumab) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

❑ ***Physician billing (HCPCS code:_____)*** ❑ ***Pharmacy billing* (NDC:_____)***

*If medication is being billed by a pharmacy, the medication should be shipped to the health care facility where it will be administered.

Dose:_____ Regimen:_____ Fill Date:_____

Billing Provider Information

SoonerCare Provider ID:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Name of outpatient health care facility where Xolair® will be delivered to and administered at:

_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Clinical Information

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

Page 1 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays*.

For Initial Authorization:

1. What is the diagnosis for which the medication is being prescribed?
   - ❑ Severe Persistent Asthma [as per National Asthma Education and Prevention Program guidelines]
   - ❑ Chronic Idiopathic Urticaria
   - ❑ Other, please list:_____
2. If diagnosis is **Severe Persistent Asthma**, please provide the following *(Initial approvals will be for the duration of 12 months)*:
   - A. Does member have a positive skin test to at least 1 perennial aeroallergen? Yes☐ No☐
     - i. If "Yes", please list perennial aeroallergen(s):_____
   - B. Please provide member's baseline IgE level:_____ IU/mL
   - C. Please provide member's weight: _____kg Date taken:_____
   - D. Has member failed a high-dose inhaled corticosteroid (≥880 mcg/day fluticasone propionate or equivalent daily dose or ≥440 mcg/day in ages 12 to 17 years) used compliantly for at least the past 3 months? Yes☐ No☐
     - i. Drug/Dose: _____
   - E. Will Xolair® be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes☐ No☐
   - F. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes☐ No☐
     - i. If "Yes", please include name of specialist:_____
   - G. Please provide the places and dates of asthma related hospitalizations and/or ER visits in the past 12 months:_____
   - H. Is member dependent on systemic corticosteroids to prevent serious asthma exacerbations? Yes☐ No☐
3. If diagnosis is **Chronic Idiopathic Urticaria**, please provide the following *(Initial approvals will be for the duration of 3 months)*:
   - A. Have other forms of urticaria been ruled out? Yes☐ No☐
   - B. Have other potential causes of urticaria been ruled out? Yes☐ No☐
   - C. Please provide member's Urticaria Activity Score (UAS):_____ Date assessed: _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
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

State of Oklahoma
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Member Name:_____ Date of Birth:_____ Member ID#:_____

Clinical Information

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For Initial Authorization, continued:

3. If diagnosis is **Chronic Idiopathic Urticaria**, please provide the following, continued:
   D. Was Xolair® prescribed by an allergist, immunologist, or dermatologist (or an advanced care practitioner with a supervising physician that is an allergist, immunologist, or dermatologist)? Yes☐ No☐
      i. If "Yes", please include name of specialist:_____
   E. Has member had a trial of a second generation H_1 antihistamine dosed 4 times the maximum FDA dose within the last 3 months for at least 4 weeks? Yes☐ No☐
      i. If "Yes", please provide the medication used, dose prescribed, and dates of use:

Medication: _____ Dose:_____ Dates of use:_____

      ii. If the second generation H_1 antihistamine trial duration was less than 4 weeks, please provide a reason why a 4-week trial is not appropriate for this member:_____
   F. Will Xolair® be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes☐ No☐

For Continued Authorization:

1. Is member compliant with therapy? Yes☐ No☐
2. If member's diagnosis includes **Chronic Idiopathic Urticaria,** please provide member's current Urticaria Activity Score (UAS):_____ Date assessed:_____
   a. If there has been no improvement in member's UAS score, please provide additional clinical information to support the continuation of Xolair® treatment: _____
      _____

Additional Information:_____
_____
_____

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

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

Pharmacist Signature: _____ **Date:** _____

Pease do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

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.*