Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization Request Form for Use of Xolair™ (omalizumab)

Member Name:	DOB:	Date:
Medicaid ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	
Requested Dose/Directions:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

Please check appropriate diagnosis and complete corresponding information:

1. ☐ **Allergic Asthma:**
   a. Prescriber practices in one of the following specialty clinics: ☐ Allergy ☐ Pulmonology ☐ Immunology
      - ***Action Required:*** If not in specialty clinic, information on annual consult with an appropriate specialist is required: Name: _____ Contact Date: _____
   b. Member must be 6 years of age or older **AND** have asthma and allergies: ☐ Yes ☐ No
   c. Member must be adherent to ICS therapy for at least 3 consecutive months:
      - Please list current ICS therapy: _____ _____
   d. Prescriber must submit **BOTH** a pretreatment serum total IgE level: _____ and current body weight: _____
   e. **Initial authorization will be granted for 1 year**
2. ☐ **Chronic Idiopathic Urticaria (CIU):**
   b. Prescriber practices in one of the following specialty clinics: ☐ Allergy ☐ Dermatology ☐ Immunology
      - ***Action Required:*** If not in specialty clinic, information on annual consult with an appropriate specialist is required: Name: _____ Contact Date: _____
   b. Member must be 12 years of age or older **AND** have a diagnosis of chronic idiopathic urticaria: ☐ Yes ☐ No

c. Member must have had an inadequate response to 2 different H_1 antihistamine trials of 4 weeks each.
   1. Drug name: _____ Date/Duration of use: _____
   2. Drug name: _____ Date/Duration of use: _____

d. **Initial authorization will be granted for 3 months**

3. ☐ <u>Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP):</u>

a. Member is 18 years of age or older: ☐ Yes ☐ No

b. Medication is prescribed by, or in consultation, with: ☐ Allergist ☐ Immunologist ☐ Otolaryngologist
   - ***Action Required:*** If not in a specialty clinic, information on annual consult with an appropriate specialist is required: Name: _____ Contact Date: _____

c. Member has clinical documentation of chronic rhinosinusitis WITH nasal polyps as evidenced by CT scan or endoscopy: ☐ Yes ☐ No

d. Member must have had an inadequate treatment response, intolerance, or contraindication to <u>both</u> of the following:
   1. **One** different intranasal corticosteroids*:
      - Name: _____Dates: _____

      **Note: Must have been adherent to therapy at optimized doses for at least <u>3</u> months.*

   2. Systemic corticosteroid trial (must be within last year): Name: _____ Dates: _____ *<u>and/or</u>* sino-nasal surgery: Surgery Date(s): _____

e. Member will concurrently use an intranasal corticosteroid: ☐ Yes ☐ No - contraindicated in member

f. Provider must include the pretreatment serum total IgE level and current body weight for dose calculation/verification: IgE level: _____ Weight: _____

   **Maximum dose allowed is 600mg every 2 weeks – please refer to package insert for dosing guide.*

g. Initial authorization will be granted for 6 months

CONTINUATION OF THERAPY:

1. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)
2. Annual specialist consult attached if prescriber is not a specialist. ☐ Yes ☐ No ☐ N/A prescriber is specialist
3. (Applies only to CRSwNP therapy) Member has been adherent to concurrent intranasal corticosteroids:

☐ Yes ☐ No

4. Documentation is attached supporting positive response to therapy as demonstrated by a reduction in the frequency and/or severity of symptoms: ☐ Yes ☐ No

Reauthorization will be issued for 1 year for Allergic Asthma and Nasal Polyps or for 6 months for CIU.

Please complete form, including required attachments and fax to: Drug Prior Authorization Unit @ 1-800-294-1350