Mountain Pacific
INNOVATING 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:

☐ INITIATION 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 three consecutive months:

Please list current ICS therapy: _____

d. Prescriber must submit **BOTH** a pretreatment serum total IgE level: _____

and current body weight: _____

Initial authorization will be granted for 1 year.

2. ☐ Chronic Idiopathic Urticaria (CIU):

a. 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 two different H1 antihistamine trials of four weeks each.

1. Drug name: _____ Date/duration of use: _____
2. Drug name: _____ Date/duration of use: _____

Initial authorization will be granted for 3 months.

3. ☐ Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP):

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 **both** of the following:

1. **One** different intranasal corticosteroid*:

Name: _____ Date: _____

*Note: Must have been adherent to therapy at optimized doses for at least **three** months.

2. Systemic corticosteroid trial (must be within last year):

Name: _____ Date: _____

and/or

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: _____

Note: Maximum dose allowed is 600mg every two weeks. Please refer to package insert for dosing guide.

Initial authorization will be granted for 6 months.

4. ☐ IgE-Mediated Food Allergy (interim criteria):

a. Member is one year of age or older: ☐ Yes ☐ No

b. Medication is prescribed by or in consultation with: ☐ Allergist ☐ Immunologist

Action required: If not in a specialty clinic, information on annual consult with an appropriate specialist is required:

Name: _____ Contact date: _____

c. Member has a diagnosis of IgE-mediated food allergy (Type I) to one or more foods: ☐ Yes ☐ No

- **Pretreatment serum total IgE level:** _____ **Date:** _____
- **Current body weight:** _____ **Date:** _____

d. Member has been placed on a food allergen avoidance program: ☐ Yes ☐ No

e. Provider attests to the following:

- Due to the black box warning risk of anaphylaxis, Xolair® will be initiated in a health care setting and only appropriate patients will be allowed to self-administer: ☐ Yes ☐ No

- Concomitant use of Xolair® and allergen immunotherapy has not been evaluated and will not be prescribed: ☐ Yes ☐ No

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 a specialist.
3. Documentation is attached supporting positive response to therapy as demonstrated by a reduction in the frequency and/or severity of symptoms: ☐ Yes ☐ No
4. **(Applies only to CRSwNP therapy. Items 1, 2 and 3 above must also be met.)**

   Member has been adherent to concurrent intranasal corticosteroids: ☐ Yes ☐ No
5. **(Applies only to IgE-mediated food allergy therapy. Items 1, 2 and 3 above must also be met.)**

   Provider attests concomitant use of Xolair® and allergen immunotherapy has not been evaluated and will not be prescribed: ☐ Yes ☐ No

Reauthorization will be issued for
12 months for Allergic Asthma, Nasal Polyps and IgE-Mediated Food Allergy
or 6 months for CIU.

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

03/2024