OKLAHOMA Health Care Authority

SoonerSelect | aetna

State of Oklahoma SoonerCare 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 3—Please complete and return <u>all</u> 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**
   - ☐ **Nasal Polyps**
   - ☐ **Immunoglobulin E (IgE)-Mediated Food Allergy**
   - ☐ **Other, please list:** _____

<u>Please select one option only:</u>

- ☐ **For Xolair® in a health care facility**
  a. Will the injection be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes☐ No☐
- ☐ **For Xolair® prefilled autoinjector or prefilled syringe for self-administration**
  a. Does member have a prior history of anaphylaxis? Yes☐ No☐
  b. Has member had at least 3 doses of Xolair® under the guidance of a health care provider with no hypersensitivity reactions? Yes☐ No☐
  c. Has member been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Xolair®? Yes☐ No☐

A. Was Xolair® prescribed by a specialist or has the member been evaluated by a specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is specialist)? Yes☐ No☐
   i. If "Yes", please include name of specialist: _____ Specialty: _____

B. Please provide member's baseline IgE level: _____ IU/mL

C. Please provide member's weight: _____kg Date taken: _____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requesteddata must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare Xolair® (Omalizumab) Prior Authorization Form

SoonerSelect | aetna

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

Clinical Information

Page 2 of 3—Please complete and return all pages. *Failure to complete all pages will result in processing delays*.
For Initial Authorization, continued:

2. If diagnosis is **Severe Persistent Asthma**, please provide the following *(Initial approvals will be for the duration of 6 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. Has member failed a medium to high-dose ICS used compliantly within the last 3-6 consecutive months? Yes☐ No☐
      i. Drug/Dose: _____
   C. Please provide the places and dates of asthma related hospitalizations and/or ER visits in the past 12 months:_____
   D. 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: _____
   D. Has the 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:_____
4. If diagnosis is **Nasal Polyps**, please provide the following *(Initial approvals will be for the duration of 6 months)*:
   A. Will Xolair® be used for add-on maintenance treatment of nasal polyps after an inadequate response to nasal corticosteroids? Yes☐ No☐
   B. Has the member had a trial of intranasal corticosteroids for, at minimum, the past 4 weeks? Yes☐ No☐
      i. If "Yes", please provide the medication used and dates of use:
         Medication: _____ Dates of use:_____
   C. Will the member continue to receive intranasal corticosteroid therapy? Yes☐ No☐
      i. If "No", does the member have a contraindication to intranasal corticosteroid therapy? Yes☐ No☐
         1. If "Yes", please provide the member's contraindication: _____
   D. Does the member have symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management ? Yes☐ No☐
   E. Does the member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy? Yes☐ No☐

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requesteddata must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	

OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare Xolair® (Omalizumab) Prior Authorization Form

SoonerSelect | aetna

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

Clinical Information

Page 3 of 3—Please complete and return all pages. *Failure to complete all pages will result in processing delays*.
For Initial Authorization, continued:

5. If diagnosis is **Immunoglobulin E-Mediated Food Allergy**, please provide the following *(Initial approvals will be for the duration of 1 year)*:
   A. Is member's diagnosis a peanut, milk, egg, wheat, cashew, hazelnut or walnut allergy confirmed by a positive skin test, positive in vitro test for food-specific IgE, or positive clinician supervised oral food challenge? Yes☐ No☐
      i. If "Yes", please list the member's allergies: _____
      ii. Please list the method used to confirm the allergy diagnosis listed above: _____

*****Documentation of allergy testing results must be submitted*****

   B. Will Xolair® be used with an allergen-avoidant diet? Yes☐ No☐
   C. Is the member or family member trained in the use of an auto-injectable epinephrine device and will have such a device available for immediate use at all times? Yes☐ No☐

For Continued Authorization:

1. Is the member compliant with therapy? Yes☐ No☐
2. Is the member responding well to therapy? Yes☐ No☐
3. 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: _____
   _____

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.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requesteddata must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	