Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Xolair (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Antidepressants Non-Formulary (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(please circle)***

Xolair (omalizumab)

Other, please specify____

Quantity ___________ Frequency ________________ Strength ____________

Route of Administration ___________ Expected Length of therapy _______________

Patient Information

Patient Name: ____________________________________

Patient ID: ____________________________________

Patient Group No.: ____________________________________

Patient DOB: ____________________________________

Patient Phone: ____________________________________

Prescribing Physician

Physician Name: ____

Specialty: ____________________________ NPI Number: __________________________

Physician Fax: ____________________________ Physician Phone: __________________________

Physician Address: ____________________________ City, State, Zip: __________________________

Diagnosis:______________________________ **ICD Code:**______________________________

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 8.]

2. Does the patient have chronic urticaria? Y N

   [If no, then skip to question 4.]

3. Are the patient’s symptoms adequately controlled on Xolair (e.g., decreased itching)? Y N

   [No further questions.]

Reference Number: C7838-A / Effective Date: 12/01/2017

4. Does the patient have asthma? Y N

   [If no, then no further questions.]

5. Has the patient experienced clinical improvement by demonstrating at least ONE of the following: A) Decreased use of rescue medications or systemic corticosteroids, or B) Reduced frequency of ED visits or hospitalizations for asthma Y N

   If yes, please indicate all that apply to patient: ____

   [If no, then no further questions.]

6. Does the patient weigh less than or equal to 150 kg (330 lbs)? Y N

   Note: Current weight is required. Requests without this information are not accepted.

   Please document patient weight: _________________________________

   [If no, then no further questions.]

7. Has the patient been compliant with their other asthma medications? Y N

   Note: Pharmacy claim history will be reviewed to confirm compliance.

   [No further questions.]

8. Does the patient have severe persistent asthma? Y N

   [If no, skip to question 17.]

9. Is Xolair prescribed by or after consultation with a pulmonologist or allergist or immunologist? Y N

   [If no, then no further questions.]

10. Did the patient have a positive skin test or allergy blood test demonstrating reactivity to at least one perennial allergen such as dust mite, animal dander, cockroach, etc? Y N

    [If no, then no further questions.]

11. Has the patient been compliant for at least 3 months with a medium to high dose inhaled corticosteroid (ICS) plus a long-acting beta agonist (LABA) or other controller medications (e.g., leukotriene receptor antagonist [LTRA] or theophylline) if intolerant to a LABA? Y N

Please document medications tried: ____

[If no, then no further questions.]

12. Has the patient's asthma remained poorly controlled while compliant with medications as demonstrated by at least ONE of the following: A) Daily use of rescue medications, B) Nighttime symptoms occurring more than once a week, or C) At least 2 exacerbations in the last year requiring additional medical treatment (systemic corticosteroids, emergency department visits, or hospitalization)? Y N

    If yes, please indicate all that apply to patient: ____

    [If no, then no further questions.]

13. Will Xolair be used in combination with IL-5 antagonists (Nucala or Cinqair)? Y N

    [If yes, then no further questions.]

14. Does the patient weigh less than or equal to 150 kg (330 lbs)? Y N

    Note: Current weight is required. Requests without this information are not accepted.

    Please document patient weight: _______________________________

    [If no, then no further questions.]

15. Did the patient have documented baseline IgE levels between 30-1500 IU/mL? Y N

    [If no, then no further questions.]

16. Is the patient at least 6 years of age? Y N

    [No further questions.]

17. Does the patient have chronic urticaria? Y N

    [If no, then no further questions.]

18. Is Xolair prescribed by an allergist, immunologist or dermatologist? Y N

    [If no, then no further questions.]

19. Has the patient experienced treatment failure or intolerable side effects with a 4-week, compliant trial of high dose cetirizine OR loratadine OR Y N

fexofenadine?

Note: Pharmacy claim history will be reviewed to confirm fills.

Please list medications and doses tried:
____

[If no, then no further questions.]

20. Has the patient experienced treatment failure or intolerable side effects with a 4-week, compliant trial of at least THREE of the following combination: A) H1 antihistamine plus leukotriene inhibitor (montelukast or zafirlukast), B) H1 antihistamine plus H2 antihistamine (ranitidine or cimetidine), C) H1 antihistamine plus doxepin, D) First generation plus a second generation antihistamine? Y N

Note: Pharmacy claim history will be reviewed to confirm fills.

Please list medication combinations tried:
____

[If no, then no further questions.]

21. Will the patient continue taking an H1 antihistamine after starting Xolair? Y N

[If no, then no further questions.]

22. Is the patient at least 12 years of age? Y N

[No further questions.]

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

____

Prescriber (Or Authorized) Signature **Date**