

OPTIMA HEALTH FAMILY CARE (MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-844-723-2094.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is NOT complete, correct, or legible, authorization can be delayed.**

Drug Requested: Xolair™ (omalizumab) (J-2357) (Medical)
Chronic Idiopathic Urticaria (CIU)

DRUG INFORMATON: Complete **all** information below or authorization will be delayed.

Drug Form/Strength/Month: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight: _____

- Maximum dosage for Xolair™ Chronic Idiopathic Urticaria - 150mg or 300mg by subcutaneous injection every 4 weeks

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **MUST** be met for approval. **ALL** documentation, including lab results and/or chart notes (**when required**), **must** be provided or request will be denied.

DIAGNOSIS: Chronic Idiopathic Urticaria. Initial Authorization Length - 12 months

- Adults and adolescents (> 12 years old) that remain symptomatic despite H1 antihistamine treatment
- Diagnosis for at least > 6 weeks with or without angioedema

Followed by: Allergist **OR** Dermatologist

AND

- Failed at least **one (1)** H1 antihistamine (4x initial dose) for **4 weeks (check applicable box below):**

<input type="checkbox"/> Levocetirizine 10mg-20mg QD	<input type="checkbox"/> Desloratidine 10-20mg QD	<input type="checkbox"/> Fexofenadine 120mg-240mg BID
<input type="checkbox"/> Cetirizine 20mg-40mg QD	<input type="checkbox"/> Loratadine 20mg-40mg QD	

AND

- Patient has remained symptomatic despite treatment with a first generation H1 antihistamine:
 - Hydroxyzine 10mg-25mg QD

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AND

- Failed at least **one (1)** Leukotriene Antagonist for **4weeks** (check applicable box below):

<input type="checkbox"/> Montelukast 10mg QD	<input type="checkbox"/> Zafirlukast 20mg BID
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AND

- Failed H₂ Antihistamine for acute exacerbations at least 5 days:

<input type="checkbox"/> Ranitidine 150mg	<input type="checkbox"/> Famotidine 20mg	<input type="checkbox"/> Cimetidine
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Reauthorization Approval Length – 12 months. Chart notes and required testing **MUST** be provided with this request form.

- Patient disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment. (Chart notes **MUST** be submitted for documentation.)

AND

- Patient symptoms has shown improvement (e.g., a decrease in the number of hives, a decrease in the size of hives, and improvement of itching)

AND

- The symptoms return when the Xolair™ dose was tapered or withheld beyond the next dosing interval. (Chart notes **must** be submitted for documentation supporting tapering of dose and/or withholding of therapy beyond the next dosing interval to see if symptoms return).

Medication being provided by (check applicable box below):

- Physician's office **OR** Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step-edit/ preauthorization criteria*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone #: _____ Fax #: _____

DEA OR NPI: _____

*Approved by Pharmacy and Therapeutic Committee: 2/21/2019
REVISED/UPDATED: 3/23/2019.