OPTIMA HEALTH COMMUNITY 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 1-844-348-3720**. 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):**

❑ Levocetirizine 10mg-20mg QD	❑ Desloratidine 10-20mg QD	❑ Fexofenadine 120mg-240mg BID
❑ Cetirizine 20mg-40mg QD	❑ 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):**

❑ Montelukast 10mg QD	❑ Zafirlukast 20mg BID

AND

❑ Failed H_2 Antihistamine for acute exacerbations at least 5 days:

❑ Ranitidine 150mg	❑ Famotidine 20mg	❑ Cimetidine

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