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. **Incomplete form will delay authorization process.**

Drug Requested: **Xolair™** (omalizumab) **(J-2357) (Medical)**

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Form/Strength/Month: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

- **Maximum dosages will be based on a patient weight of 150kg. and Chronic Idiopathic Urticaria: Xolair™ 150mg or 300mg by subcutaneous injection every 4 weeks**

CLINICAL CRITERIA: Check applicable boxes below. **ALL** lines **MUST** be checked. To qualify, chart notes and labs **must** be attached to this request. Authorization may be delayed if incomplete.

❑ **Moderate to severe persistent asthma** with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms are inadequately controlled with inhaled corticosteroids

Followed by: ❑ Allergist **OR** ❑ Pulmonologist

AND

High utilizer:

❑ 4 ED visits (last 12months) **OR**

❑ 2 Hospitalizations annually **AND**

❑ Currently on daily high dose inhaled corticosteroids (at least 90 days consecutively within the year of request) **AND**

❑ Long acting beta agonist at least 90 days consecutively within the year of request (Ex. Advair® 500mcg/50mcg BID or equivalent/day) **AND**

❑ Patient at least 6 years old **AND**

❑ Pretreatment IgE level of 30-700: _____ Test Date: _____

(level of IgE will be approved based on date of lab after 90 days therapy and daily high dose inhaled corticosteroids and long acting beta agonist at least 90 days consecutively)

❑ Current Weight: _____ Date weight was taken: _____

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Reauthorization Approval for Moderate to Severe Persistent Asthma: Length is for 12 months. Chart notes and required testing **MUST** be submitted with this request form.

- ❑ Patient has experienced improvement with treatment as defined by one of the following:
  - ❑ Decreased in emergency room visits within the last 12 months _____ **(must document number) OR**
  - ❑ Decrease in hospitalizations within the last 12 months _____ **(must document number) OR**
  - ❑ Decreased frequency of exacerbations **(defined as worsening of asthma that requires an increase in inhaled corticosteroid dose or treatment with systemic corticosteroids) (will be verified through paid pharmacy claims) OR**
  - ❑ Decreased utilization of rescue medication **(will be verified through paid pharmacy claims)**

Diagnosis: Chronic Idiopathic Urticaria. Initial Approval – Length is for 12 months

- ❑ **Chronic Idiopathic Urticaria** in adults and adolescents (> 12 years old) remain symptomatic despite H1 antihistamine treatment.
- ❑ Diagnosis for at least > 6weeks with or without angioedema

Followed by: ❑ Allergist **OR** ❑ Dermatologist

- ❑ Failed at least one (1) H1 antihistamine (4x initial dose) for **4 weeks**: **(Please 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

AND

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

❑ Montelukast 10mg QD	❑ Zafirlukast 20mg BID

Reauthorization Approval for Chronic Idiopathic Urticaria: Length is for 12 months.
Chart notes and required testing **MUST** be submitted 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.)**

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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)**

OR

- ❑ 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: _____

REVISED/UPDATED: ~~8/1/2017; 9/1/2018; 10/8/2018;~~ **2/17/2019**