OPTIMA HEALTH PLAN

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.**

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

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 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.)**

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