BlueCross BlueShield Federal Employee Program

XOLAIR
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Xolair (omalizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   ❑Asthma
   a. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes* ❑No
      If YES, please specify the medication: _____
   b. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***
      ❑**INITIATION** of therapy, please answer the following questions:
      i. Does the patient have moderate to severe asthma? ❑Yes ❑No
      ii. What is the patient's baseline (pre-treatment) serum IgE? _____ IU/mL ❑Test not completed
      iii. Has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting beta2-agonist within the past 6 months? ❑Yes ❑No*
         If NO, has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past 6 months? ❑Yes ❑No
      iv. Does the patient have a positive skin prick test response **OR** a positive RAST response to at least one common allergen? ❑Yes ❑No
      ❑**CONTINUATION (PA renewal)** of therapy, please answer the following questions:
      i. Has the patient had a break or interruption in treatment? ❑Yes* ❑No
         If YES, please answer the following questions:
         1) Has the interruption in treatment lasted 1 year or longer? ❑Yes ❑No
         2) Has the patient's serum IgE level been re-tested since the interruption in treatment? ❑Yes* ❑No
            If YES, what is the patient's re-tested serum IgE? _____ IU/mL
      ii. Has the patient had decreased exacerbations or an improvement in symptoms? ❑Yes ❑No
      iii. Has the patient had decreased utilization of rescue medications? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑ Chronic rhinosinusitis with nasal polyps (CRSwNP)

a. Will this medication be used in combination with another monoclonal antibody for the treatment of CRSwNP? ❑Yes* ❑No ***If YES***, please specify the medication:_____

b. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No

c. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

❑ **INITIATION** of therapy, please answer the following questions:

i. What is the patient's baseline (pre-treatment) serum IgE? _____ IU/mL ❑Test not completed

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of **TWO** nasal corticosteroid sprays (i.e., mometasone, fluticasone, budesonide, or triamcinolone)? ❑Yes ❑No

❑ **CONTINUATION (PA renewal)** of therapy, please answer the following questions:

i. Has the patient had improvements in sino nasal symptoms? ❑Yes ❑No

ii. Has the patient had a break or interruption in treatment? ❑Yes* ❑No

If YES, please answer the following questions:

1) Has the interruption in treatment lasted 1 year or longer? ❑Yes ❑No

2) Has the patient's serum IgE level been re-tested since the interruption in treatment? ❑Yes* ❑No

If YES, what is the patient's re-tested serum IgE? _____ IU/mL

❑ Chronic spontaneous urticaria (CSU)

a. Will this medication be used in combination with another monoclonal antibody for the treatment of CSU? ❑Yes* ❑No ***If YES***, please specify the medication:_____

b. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following question:

i. Does the patient have a baseline *urticarial activity score (UAS)? ❑Yes* ❑No

If YES, please specify score: _____

Urticarial Activity Score: **https://www.mdcalc.com/urticaria-activity-score-uas**

ii. Has the patient remained symptomatic after at least **TWO** previous trials of H1-antihistamines? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient's urticaria activity score (UAS) decreased, such as improvement in pruritic wheals, hives, and itching? ❑Yes* ❑No

If YES, please specify score: _____

Urticarial Activity Score: **https://www.mdcalc.com/urticaria-activity-score-uas**

❑ IgE-mediated food allergy

a. Will this medication be used for the reduction of allergic reactions that may occur with accidental exposure to one or more foods? ❑Yes ❑No

b. Will this medication be used in conjunction with food allergen avoidance? ❑Yes ❑No

c. Will this medication be used for emergency treatment of allergic reactions, including anaphylaxis? ❑Yes ❑No

d. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

❑ **INITIATION** of therapy, please answer the following questions:

i. What is the patient's baseline (pre-treatment) serum lgE? _____ IU/mL ❑Test not completed

ii. Is the patient allergic to peanut **AND** at least two other foods (e.g., milk, egg, wheat, cashew, hazelnut, or walnut) with positive food specific IgE greater than or equal to 6 kUA/L for each? ❑Yes ❑No

❑ **CONTINUATION (PA renewal)** of therapy, please answer the following question:

i. Has the patient had a break or interruption in treatment? ❑Yes* ❑No

If YES, please answer the following questions:

1) Has the interruption in treatment lasted 1 year or longer? ❑Yes ❑No

2) Has the patient's serum IgE level been re-tested since the interruption in treatment? ❑Yes* ❑No

If YES, what is the patient's re-tested serum IgE? _____ IU/mL

❑ Other diagnosis ***(please specify):*** _____

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To ensure a quick and accurate response to your prior approval request, please submit **medical records (e.g., chart notes, laboratory values)** pertaining to the diagnosis only. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a **guideline** of what documentation is required to process the prior authorization request.

***For more efficient processing, please provide the page number of the documented information in the medical record**

Documentation Required for Diagnoses:

❑**Asthma**

- 6 years of age or older **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Moderate to severe asthma
  - Positive skin prick test or RAST response to at least 1 common allergen
  - Inadequate control of symptoms after a minimum 3 months of compliant use with **ONE** of the following within the past 6 months:
    - Inhaled corticosteroids & long acting $beta_2$ agonist
    - Inhaled corticosteroids & long acting muscarinic antagonist
  - Baseline serum IgE level
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Decreased exacerbations **OR** improvement in symptoms
  - Decreased utilization of rescue medications
  - **NO** interruption in therapy 1 year or greater **OR** interruption lasting 1 year or more requires re-testing with a serum IgE level ≥ 30 IU/mL

❑**Chronic rhinosinusitis with nasal polyps (CRSwNP)**

- 18 years of age or older **PAGE _____ of _____**
- Used as add-on maintenance treatment **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Inadequate response, intolerance, or contraindication to a 3-month trial of **TWO** nasal corticosteroid sprays: budesonide, fluticasone, mometasone, or triamcinolone
  - Baseline serum IgE level
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Interruption lasting 1 year or more require re-testing of total serum IgE level

❑**Chronic spontaneous urticaria (CSU)**

- 12 years of age or older **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Symptomatic after at least **TWO** previous trials of H1-antihistamines
  - Baseline urticaria activity score (UAS): **https://www.mdcalc.com/urticaria-activity-score-uas**
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Decrease in urticaria activity score (UAS), such as improvement in pruritic wheals, hives, and itching

❑**IgE-mediated food allergy**

- 1 year of age or older **PAGE _____ of _____**
- Used for the reduction of allergic reactions that may occur with accidental exposure to one or more foods **PAGE _____ of _____**
- Used in conjunction with food allergy avoidance **PAGE _____ of _____**
- **NOT** for emergency treatment of allergic reactions, including anaphylaxis **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Patient is allergic to peanut **AND** at least two other foods with positive food specific IgE ≥ 6 kUA/L for each
  - Baseline serum IgE level
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - **NO** interruption in therapy 1 year or greater **OR** interruption lasting 1 year or more requires re-testing with a serum IgE level ≥ 30 IU/mL