



## Xolair® (Omalizumab) Prior Authorization Initial Request Form

### Beneficiary Information

Name: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Billing Provider Information (Pharmacy, Physician, or Facility)

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Requested Drug: \_\_\_\_\_ NDC: \_\_\_\_\_  
Requested Procedure Code (if applicable): \_\_\_\_\_ Total # of Units Requested (per 6 months): \_\_\_\_\_

### Prescriber Information

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Requested Information

1. What is specialty of the provider?  Pulmonologist  Allergist  Immunologist
2. Please indicate diagnosis for which Xolair® is being prescribed:  
\_\_\_\_\_
3. Date diagnosed: \_\_\_\_\_
4. Does patient have a positive skin test or in vitro reactivity to a perennial aeroallergen?  Yes  No
5. Is patient compliant with taking a high-dose inhaled corticosteroid and a long-acting beta<sub>2</sub>-agonist?  Yes  No
6. Is patient symptomatic of Chronic Idiopathic Urticaria despite H1 antihistamine treatment?  Yes  No
7. Please provide all of the following:  
Dosage: \_\_\_\_\_  
Administration schedule:  Every 2 wks  Every 4 weeks  
Pre-Treatment Serum IgE (IU/ml):  ≥30-100  >100-200  >300-400  >400-500  >500-600  >600-700  
Body Weight:  30-60 kg  >60-70 kg  >70-90 kg  >90-150kg
8. For asthma diagnosis, please fill out page 2.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.  
This form will be returned unprocessed if it is not completed in its entirety.**

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Please circle one box for each Component of Asthma Severity below:

Components of Asthma Severity				
<b>Symptoms</b>	≤2 days/week	>2 days/week but not daily	Daily	Throughout Day
<b>Nighttime awakenings</b>	≤2x/month	3-4x/month	>1x/week but not nightly	Often 7x/week
<b>Short-acting beta<sub>2</sub>-agonist use for symptom control (not prevention of EIB)</b>	≤2 days/week	>2 days/week but not daily, and not more than 1x on any day	Daily	Several times per day
<b>Interference with normal activity</b>	None	Minor limitation	Some limitation	Extremely limited
<b>Lung Function**</b>	<ul style="list-style-type: none"> <li>• Normal FEV<sub>1</sub> between exacerbations</li> <li>• FEV<sub>1</sub> &gt;80% predicted</li> <li>• FEV<sub>1</sub>/FVC normal</li> </ul>	<ul style="list-style-type: none"> <li>• FEV<sub>1</sub> &gt;80% predicted</li> <li>• FEV<sub>1</sub>/FVC normal</li> </ul>	<ul style="list-style-type: none"> <li>• FEV<sub>1</sub> &gt;60% but &lt;80% predicted</li> <li>• FEV<sub>1</sub>/FVC reduced 5%</li> </ul>	<ul style="list-style-type: none"> <li>• FEV<sub>1</sub> &lt;60% predicted</li> <li>• FEV<sub>1</sub>/FVC reduced &gt;5%</li> </ul>

\*\* Normal FEV<sub>1</sub>/FVC is defined below:

8-19 yr 85%; 20-39 yr 80%; 40-59 yr 75%; 60-80 yr 70%

Please circle one box for each Component of Asthma Control below:

Components of Asthma Control			
<b>Symptoms</b>	≤2 days/week	>2 days/week but not daily	Throughout the day
<b>Nighttime awakenings</b>	≤2x/month	1-3x/week	≥4x/week
<b>Interference with normal activity</b>	None	Some limitation	Extremely limited
<b>Short-acting beta<sub>2</sub>-agonist use for symptom control (not prevention of EIB)</b>	≤2 days/week	>2 days/week	Several times per day
<b>FEV<sub>1</sub> or peak flow</b>	>80% predicted/personal best	60-80% predicted/personal best	<60% predicted/personal best
<b>Validated questionnaires</b>	<ul style="list-style-type: none"> <li>• 0</li> <li>• ≤0.75*</li> <li>• ≥20</li> </ul>	<ul style="list-style-type: none"> <li>• 1-2</li> <li>• ≥1.5</li> <li>• 16-19</li> </ul>	<ul style="list-style-type: none"> <li>• 3-4</li> <li>• N/A</li> <li>• ≤15</li> </ul>