Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Xolair (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Xolair (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Xolair (omalizumab)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 8.]

2. Does the member have chronic urticaria? Y N

   [If no, then skip to question 4.]

3. Are the member's symptoms adequately controlled on Xolair (for example, decreased itching)? Y N

   [No further questions.]

4. Does the member have asthma? Y N

   [If no, then no further questions.]

5. Has the member experienced clinical improvement (for example, decreased use of rescue medications or systemic corticosteroids, reduction in number of emergency department visits or hospitalizations)? Y N

   If yes, please indicate all that apply to member:

   _____

   [If no, then no further questions.]

6. Does the member weigh less than or equal to 150 kilograms (330 pounds)? Y N

   Note: Current weight is required. Requests without this information are not accepted.

   Please document member weight: _____

   [If no, then no further questions.]

7. Has the member been compliant with their other asthma medications? Y N

   Note: Pharmacy claim history will be reviewed to confirm compliance.

   [No further questions.]

8. Does the member have a diagnosis of moderate to severe persistent asthma? Y N

   [If no, skip to question 17.]

9. Is Xolair prescribed by, or after consultation with a pulmonologist or allergist/immunologist? Y N

   [If no, then no further questions.]

10. Did the member have a positive skin test or in vitro reactivity to at least one perennial allergen such as dust mite, animal dander, cockroach, etc.? Y N

    [If no, then no further questions.]

11. Has the member been compliant for at least 3 months with a medium to high dose inhaled corticosteroid (ICS) plus a long-acting beta agonist (LABA) or other controller medications (for example, leukotriene receptor antagonist [LTRA] or theophylline) if intolerant to a LABA? Y N

Please document medications tried:

_____

[If no, then no further questions.]

12. Has the member's asthma remained poorly controlled while compliant with medications as demonstrated by at least ONE of the following: A) daily use of rescue medications (short-acting inhaled beta-2 agonists), B) nighttime symptoms occurring more than once a week, or C) at least 2 exacerbations in the last year requiring additional medical treatment (systemic corticosteroids, emergency department visits, or hospitalization)? Y N

    If yes, please indicate all that apply to member:

    _____

    [If no, then no further questions.]

13. Will Xolair be used in combination with interleukin 5 (IL-5) antagonists (Nucala or Cinqair)? Y N

    [If yes, then no further questions.]

14. Does the member weigh less than or equal to 150 kg (330 lbs)? Y N

    Note: Current weight is required. Requests without this information are not accepted.

    Please document member weight: _____

    [If no, then no further questions.]

15. Did the member have documented baseline IgE (Immunoglobulin E) level between 30 and 1300 IU/mL? Y N

    [If no, then no further questions.]

16. Is the member at least 6 years of age? Y N

    [No further questions.]

17. Does the member have a diagnosis of chronic urticaria? Y N

    [If no, then no further questions.]

18. Is Xolair prescribed by an allergist/immunologist or dermatologist? Y N

    [If no, then no further questions.]

19. Has the member experienced treatment failure or intolerable side effects with a 4-week, compliant trial of high dose cetirizine OR loratadine OR Y N

fexofenadine?

Note: Pharmacy claim history will be reviewed to confirm fills.

Please list medications and doses tried:

_____

[If no, then no further questions.]

20. Has the member experienced treatment failure or intolerable side effects with a 4-week, compliant trial of at least THREE of the following combinations: A) H1 antihistamine plus leukotriene inhibitor (montelukast or zafirlukast), B) H1 antihistamine plus H2 antihistamine (ranitidine or cimetidine), C) H1 antihistamine plus Doxepin, D) first generation plus a second generation antihistamine? Y N

    Note: Pharmacy claim history will be reviewed to confirm fills.

    Please list medication combinations tried:

    _____

    [If no, then no further questions.]

21. Will the member continue taking an H1 antihistamine after starting Xolair? Y N

    [If no, then no further questions.]

22. Is the member at least 12 years of age? Y N

    [No further questions.]

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**