Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Xolair (omalizumab)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient at least 6 years of age for the treatment of moderate to severe allergic asthma or at least 12 years of age for the treatment of chronic idiopathic urticaria?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of moderate to severe allergic asthma or clinically documented severe persistent asthma?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of chronic idiopathic urticaria (CIU)?

☐ Yes ☐ No

Q4. Has the patient tried and failed all standard treatments for chronic urticaria? A. Non-sedating second generation H1 antihistamines at standard dosing. B. Increasing the dose of the nonsedating H1 antihistamine (such as, cetirizine 10 mg twice daily), adding a different second generation antihistamine (such as, fexofenadine 180 mg in the morning, and cetirizine 10 mg at night), addition of montelukast (10mg daily) or adding or substituting a first generation H1 antihistamine. Please note prior authorization will be required. C. Maintaining the highest effective and tolerated dose of H1 antihistamines. Please note prior authorization will be required.

☐ Yes ☐ No

Q5. Has the patient remained symptomatic despite above stepwise approach?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does patient require frequent and repeated courses of oral glucocorticoids, or extended periods of glucocorticoid treatment (months at a time)?

☐ Yes ☐ No

Q7. Has the patient been prescribed or recommended Xolair by a dermatologist or allergist?

☐ Yes ☐ No

Q8. Does the patient have reversible airflow obstruction or challenged bronchial hyperactivity?

☐ Yes ☐ No

Q9. Has the patient tried and failed short-term treatment course of oral corticosteroids and combination therapies (high dose inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

☐ Yes ☐ No

Q10. Is the patient intolerant to short-term treatment course of oral corticosteroids and combination therapies (high dose inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline) for at least for three months and has been compliant for at least three months?

☐ Yes ☐ No

Q11. Has the patient been prescribed or recommended Xolair by a pulmonologist or allergist?

☐ Yes ☐ No

Q12. Does the patient have asthma symptoms such as coughing, wheezing and dyspnea 2 or more days per week?

☐ Yes ☐ No

Q13. Does the patient use a rescue inhaler such as a short acting beta2-agonist 2 or more days per week?

☐ Yes ☐ No

Q14. Does the patient have asthma attacks / exacerbations two or more times per week?

☐ Yes ☐ No

Q15. Has the patient had multiple visits to the emergency room in the previous 12 months?

☐ Yes ☐ No

Q16. Does the patient have one or more nights of nocturnal asthma causing awakening?

☐ Yes ☐ No

Q17. Does the patient have FEV1 greater than 40% to less than 80% of predicted normal? (Labs must be attached)

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q18. Does the patient have non-smoking status?

☐ Yes ☐ No

Q19. Is there documentation of positive skin test, RAST, or in vitro reactivity to at least one perennial aeroallergen? (Labs must be attached)

☐ Yes ☐ No

Q20. Are there clinical documentation showing IgE levels between 30-700 IU/ml in patients over the age of 12; for children ages 6 to 12 years old documentation of IgE levels between 30-1300IU/mL? (Labs must be attached)

☐ Yes ☐ No

Q21. Requested Duration:

☐ 6 Months (Asthma) ☐ 3 Months (CIU)

Q22. Additional Information:

Prescriber Signature

Date

Updated 2018