



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES



Office of Pharmacy Service
Prior Authorization Criteria

Xolair® (Omalizumab)

Effective 02/27/2019

Prior Authorization Request Form

Xolair is an anti-IgE antibody indicated for:

- *Moderate to severe persistent asthma in patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids.*
- *Chronic idiopathic urticaria in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment.*

Prior authorization requests for Xolair may be approved if the following criteria are met:

For moderate to severe persistent asthma

- 1) Patient is six (6) years of age or older; **AND**
- 2) Must be prescribed by a board-certified pulmonologist or board-certified allergist; **AND**
- 3) Current body weight is between 20kg and 150kg; **AND**
- 4) If the patient currently smokes they must be enrolled in a smoking cessation program; **AND**
- 5) Patient is symptomatic despite receiving recommended first line treatments (including high dose inhaled corticosteroids + LABA) and exhibiting compliance with those treatments; **AND**
- 6) Patient has reacted positively to a perennial aeroallergen skin or blood test; **AND**
- 7) Patient must have an IgE level not less than 30 IU/ml or more than the Manufacturer's recommendation, based on weight. (The patient's weight and pretreatment serum IgE must be presented to review dosing).

For moderate to severe Chronic Idiopathic Urticaria:

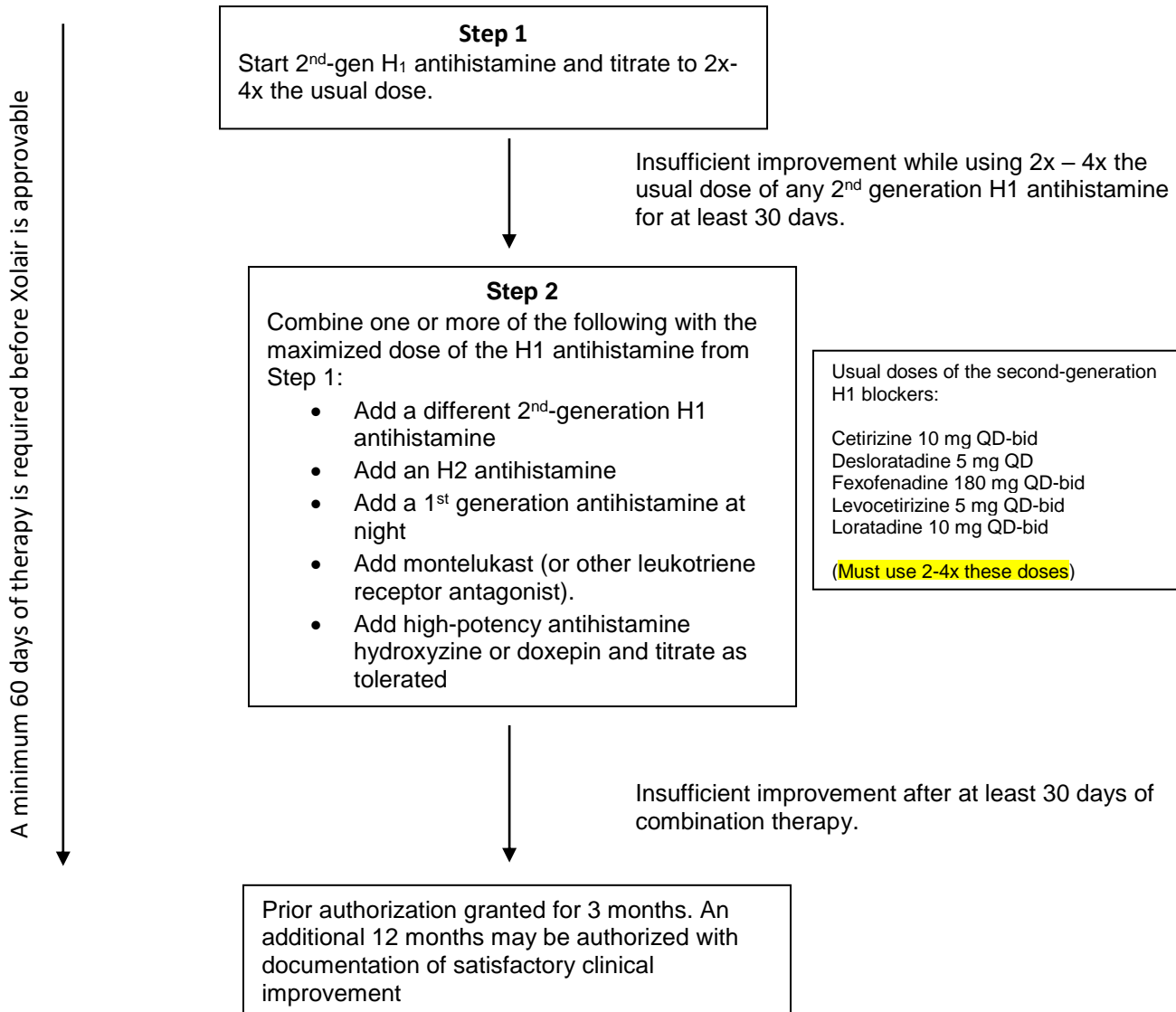
- 1) Current diagnosis must be Chronic Idiopathic Urticaria, (documentation supporting diagnosis must be provided with PA request); **AND**
- 2) Patient must be twelve (12) years of age or older; **AND**
- 3) Prescribed written by a board-certified Allergist, Immunologist, or Dermatologist; **AND**
- 4) Patient must have documented failure of 60-days of therapy with a 2nd-generation H1 antihistamine prescribed at 2x – 4x the usual dose; **AND**
- 5) At least 30 days of therapy using a combination of a 2nd-generation H1 antihistamine (prescribed at 2x – 4x the usual dose) concurrent with one or more of the following treatment options:
 - a. Add a different 2nd-generation H1 antihistamine
 - b. Add an H2 antihistamine
 - c. Add a 1st generation antihistamine at night
 - d. Add montelukast (or other leukotriene receptor antagonist).
 - e. Add high-potency antihistamine hydroxyzine or doxepin and titrate as tolerated
- 6) Patients who do not tolerate at least 2x the normal listed dose of the 2nd generation H1 antihistamines (see below) will be required to try each agent (and possibly combinations of these agents) until they either tolerate one of them to the required dosing range or they have documented intolerance to all of them.



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES



SUMMARY OF STEP THERAPY REQUIREMENTS FOR TREATMENT OF CIU



References:

- 1) Xolair® (package insert) Genentech Inc. South San Francisco, CA. 5/2018
- 2) Lexi-Comp™ Xolair monograph and Clinical Consult™ application 9/182018.
- 3) Asthma Care – Guidelines from the National Asthma Education and Prevention Program (2012)
- 4) Global Initiative for Asthma – 2018 guidelines
- 5) <https://www.aafp.org/afp/2017/0601/p717.html> (source for algorithm)
- 6) The EAACI/GA²LEN/EDF/WAO guideline for the definition, classification, diagnosis and management of urticaria. *Allergy*. 2018 Jul;73(7):1393-1414. doi: 10.1111/all.13397.