XOLAIR® Prior Authorization Form

(omalizumab)

West Virginia Medicaid
Drug Prior Authorization Form

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) (First) (M) WV Medicaid 11 Digit ID# Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) (First) (MI) (Specialty)

Prescriber Address (Street) (City) (State) (Zip)

Prescriber 10-Digit NPI# Phone # (111-222-3333) Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) (City) (State) (Zip)

Pharmacy 10-Digit NPI# Phone # (111-222-3333) Fax # (111-222-3333)

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Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

XOLAIR® Sub-Q Injection - will only be approved for a Diagnosis of Asthma or Chronic Idiopathic Urticaria

Diagnosis (Include ICD Code)	Strength	Directions for Use
	150 mg	

For Diagnosis of Asthma

Does the patient have a diagnosis of moderate to severe persistent allergic asthma? ☐ Yes ☐ No not approved

Age of patient? ☐ Over 12 ☐ 6 - 12 ☐ Under 6 not approved

Is the patient's current weight between 20kg and 150kg? ☐ Yes ☐ No not approved

Weight in kg:

Is the patient symptomatic despite receiving other recommended first-line treatments? ☐ Yes List previously failed treatments and other concurrent medications (See criteria for requirements.) ☐ No not approved

Has the patient been compliant with other recommended first-line treatments? ☐ Yes ☐ No - (explain)

Has the patient reacted positively to a perennial aeroallergen skin or blood test?	☐ Yes ☐ No	Date of test	
Baseline IgE Level:		Date of test	
Are you a board certified pulmonologist or allergist? ☐ Yes ☐ No - please answer next question		Was treatment recommended by a board certified pulmonologist or a board certified allergist?	☐ Yes ☐ No

For Diagnosis of moderate to severe Chronic Idiopathic Urticaria

Does the patient have a diagnosis of Chronic Idiopathic Uticaria? ☐ Yes ☐ No

Is the patient 12 years of age or older? ☐ Yes ☐ No

Is there a documented failure of, or contraindication to, maximum tolerable dosing of scheduled H-1 antihistamine, leukotriene inhibitor, and immunosuppresive therapies? Is so, documentation must be submitted with request. ☐ Yes ☐ No

Is there evidence of an evaluation that excludes other medical diagnoses associated with chronic urticaria? If so, documentation must be submitted with request. ☐ Yes ☐ No

Are you a board certified allergist, immunologist or dermatologist? ☐ Yes ☐ No

Prior Authorization requests will be initially granted for three (3) months. Further prior authorization will be granted for an additional 12 months after documented receipt of therapy success. Please see PA criteria for documentation needed for therapy success.

Other pertinent information, please provide additional sheets as necessary.

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature ____________

Date: (MM/DD/YYYY) ____________