US Family Health Plan
Prior Authorization Request Form for
omalizumab **(Xolair) syringe**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires after one year. Renewal PA criteria will be approved indefinitely.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Xolair syringe*	☐ Yes Proceed to question **2**	☐ No Skip to question **6**
2. What is the indication or diagnosis?	☐ Asthma - Proceed to question **3** ☐ Chronic rhinosinusitis with nasal polyposis - Proceed to question **4** ☐ Chronic Idiopathic Urticaria (CIU) - Proceed to question **5** ☐ Other - **STOP Coverage not approved**	
3. Has the patient had a positive response to therapy with a decrease in asthma exacerbations or improvements in forced expiratory volume in one second (FEV1)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Is there evidence of effectiveness as documented by decrease in nasal polyps score or nasal congestion score?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Has the patient had a positive response to therapy and improvement in clinical symptoms to warrant maintenance of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
6. Does the provider ensure that patient has no prior history of anaphylaxis, including to the requested medication or other agents, such as foods, drugs, biologics, etc?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

USFHP Prior Authorization Request Form for omalizumab **(Xolair) syringe**

7. Has the patient received at least 3 doses of the requested medication under the guidance of a healthcare provider with no hypersensitivity reactions?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the provider ensure that patient or caregiver is able to recognize symptoms of anaphylaxis presenting as bronchospasm, hypotension, syncope, urticaria, and/or angioedema of the throat or tongue?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the provider ensure that patient or caregiver is able to treat anaphylaxis appropriately and considered co-prescribing epinephrine?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the provider ensure that patient or caregiver is able to perform subcutaneous injections with the requested medication prefilled syringe with proper technique according to the prescribed dosing regimen?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient currently receiving another immunobiologic (such as, benralizumab [Fasenra], mepolizumab [Nucala], or dupilumab [Dupixent])?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 12
12. What is the indication or diagnosis?	☐ Asthma - Proceed to question 1**3** ☐ Chronic rhinosinusitis with nasal polyposis - Proceed to question **17** ☐ Chronic Idiopathic Urticaria (CIU) - Proceed to question **22** ☐ Other - **STOP Coverage not approved**	
13. Is the patient 6 years of age or older?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the drug prescribed by an allergist, immunologist, pulmonologist, or asthma specialist?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Does the patient have moderate to severe asthma with baseline IgE levels that are greater than 30 IU/ml?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Has the patient tried and failed an adequate course (3 months) of two of the following while using a high-dose inhaled corticosteroid: • **Long-acting beta agonist (LABA such as, Serevent, Striverdi),** • **Long acting muscarinic antagonist (LAMA such as Spiriva, Incruse), or** • **Leukotriene receptor antagonist (such as, Singulair, Accolate, Zyflo)?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

17. Is the patient 18 years of age or older?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Is the drug prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Does the patient have chronic rhinosinusitis with nasal polyposis defined by all of the following: • **Presence of nasal polyposis is confirmed by imaging or direct visualization AND** • **At least two of the following: mucopurulent discharge, nasal obstruction and congestion, decreased or absent sense of smell, or facial pressure and pain?**	☐ Yes Proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. Will the requested medication only be used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation?	☐ Yes Proceed to question **21**	☐ No **STOP** **Coverage not approved**
21. Do the symptoms of chronic rhinosinusitis with nasal polyposis continue to be inadequately controlled despite all of the following treatments: • **Adequate duration of at least TWO different high-dose intranasal corticosteroids AND** • **Nasal saline irrigation AND** • **The patient has a past surgical history or endoscopic surgical intervention or has a contraindication to surgery?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
22. Is the patient 12 years of age or older?	☐ Yes Proceed to question **23**	☐ No **STOP** **Coverage not approved**
23. Is the drug prescribed by an allergist, immunologist, or dermatologist?	☐ Yes Proceed to question **24**	☐ No **STOP** **Coverage not approved**
24. Is the requested medication being prescribed for chronic idiopathic urticarial and not for another form of urticaria?	☐ Yes Proceed to question **25**	☐ No **STOP** **Coverage not approved**
25. Has the patient experienced symptoms for greater than 6 weeks?	☐ Yes Proceed to question **26**	☐ No **STOP** **Coverage not approved**
26. Does the patient remain symptomatic despite a 4 week trial with a recommended urticarial dosing of a second generation H1 antihistamine (such as, cetirizine, levocetirizine, loratadine, desloratadine, fexofenadine)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

USFHP Prior Authorization Request Form for omalizumab **(Xolair) syringe**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature	Date

[07 May 2021]