US Family Health Plan

Prior Authorization Request Form for

Omalizumab (Xolair) syringe, autoinjector

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 of prior authorization 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 TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Xolair syringe or Xolair autoinjector*	☐ Yes Proceed to question **2**	☐ No Proceed to question **7**
2. **What is the indication or diagnosis?**	☐ Asthma - Proceed to question **3** ☐ Chronic rhinosinusitis with nasal polyposis - Proceed to question **4** ☐ hronic Idiopathic Urticaria (CIU) - Proceed to question **5** ☐ Food allergy - Proceed to question **6** ☐ 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**

Omalizumab (Xolair) syringe, autoinjector

Question		
6. Does the provider acknowledge that the patient will continue to be counseled on the following: (1) the requested medication does not eliminate food allergy and patient must continue to avoid food allergen; (2) the need for access to an epinephrine injector; (3) the requested medication is not intended to treat emergencies?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
7. Does the provider acknowledge that the requested medication carries a black box warning for anaphylaxis, should be initiated in a healthcare setting, and self-administration of the requested medication should be based on criteria to mitigate risk from anaphylaxis?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient received OR will receive at least 3 doses of the requested medication under the guidance of a healthcare provider with no hypersensitivity reactions?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the provider agree to ensure that the patient or caregiver is able to recognize symptoms of anaphylaxis?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the provider agree to ensure that the patient or caregiver is able to treat anaphylaxis appropriately with co-prescribing epinephrine?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the provider ensure that patient or caregiver is able to perform subcutaneous injections with the requested medication with proper technique according to the prescribed dosing regimen?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. 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 **13**
13. What is the requested medication?	☐ XOLAIR Prefilled Syringe - Proceed to question **14** ☐ XOLAIR Autoinjector - Proceed to question **15**	
14. For XOLAIR Prefilled Syringe, provider acknowledges:	☐ Less than 1 years of age - **Coverage not approved** ☐ Greater than or equal to 1 years of age and Less than 12 years of age: Administer by caregiver - Proceed to question **16** ☐ Greater than or equal to 12 years of age: device may be self-administered, or under adult supervision for pediatric patients. - Proceed to question **16**	

<table>
<tr><td>15. For XOLAIR Autoinjector, provider acknowledges:</td><td colspan="2">☐ Less than 12 years of age - Coverage not approved
☐ Greater than or equal to 12 years of age: device may be self-administered, or under adult supervision for pediatric patients - Proceed to question 16</td></tr>
<tr><td>16. What is the indication or diagnosis?</td><td colspan="2">☐ Asthma - Proceed to question 17
☐ Chronic rhinosinusitis with nasal polyposis - Proceed to question 21
☐ Chronic Idiopathic Urticaria (CIU) - Proceed to question 26
☐ Food allergy - Proceed to question 31
☐ Other - STOP Coverage not approved</td></tr>
<tr><td>17. Is the patient 6 years of age or older?</td><td>☐ Yes
Proceed to question 18</td><td>☐ No
STOP
Coverage not approved</td></tr>
<tr><td>18. Is the drug prescribed by an allergist, immunologist, pulmonologist, or asthma specialist?</td><td>☐ Yes
Proceed to question 19</td><td>☐ No
STOP
Coverage not approved</td></tr>
<tr><td>19. Does the patient have moderate to severe asthma with baseline IgE levels that are greater than 30 IU/ml?</td><td>☐ Yes
Proceed to question 20</td><td>☐ No
STOP
Coverage not approved</td></tr>
<tr><td>20. 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)?</td><td>☐ Yes
Sign and date below</td><td>☐ No
STOP
Coverage not approved</td></tr>
<tr><td>21. Is the patient 18 years of age or older?</td><td>☐ Yes
Proceed to question 22</td><td>☐ No
STOP
Coverage not approved</td></tr>
<tr><td>22. Is the drug prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist?</td><td>☐ Yes
Proceed to question 23</td><td>☐ No
STOP
Coverage not approved</td></tr>
</table>

23. 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 **24**	☐ No **STOP** **Coverage not approved**
24. 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 **25**	☐ No **STOP** **Coverage not approved**
25. 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**
26. Is the patient 12 years of age or older?	☐ Yes Proceed to question **27**	☐ No **STOP** **Coverage not approved**
27. Is the drug prescribed by an allergist, immunologist, or dermatologist?	☐ Yes Proceed to question **28**	☐ No **STOP** **Coverage not approved**
28. Is the requested medication being prescribed for chronic idiopathic urticarial and not for another form of urticaria?	☐ Yes Proceed to question **29**	☐ No **STOP** **Coverage not approved**
29. Has the patient experienced symptoms for greater than 6 weeks?	☐ Yes Proceed to question **30**	☐ No **STOP** **Coverage not approved**
30. 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**
31. Is the drug prescribed by an allergist or immunologist?	☐ Yes Proceed to question **32**	☐ No **STOP** **Coverage not approved**
32. Does the patient have a documented history of food allergy?	☐ Yes Proceed to question **33**	☐ No **STOP** **Coverage not approved**

33. Is the patient currently receiving oral, IM, or IV corticosteroids, tricyclic antidepressants, or B-blockers (oral or topical)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **34**
34. Does the provider acknowledge that clinical trials excluded those with a history of severe anaphylaxis, uncontrolled or severe asthma, uncontrolled atopic dermatitis, or eosinophilic gastrointestinal disease?	☐ Yes Proceed to question **35**	☐ No **STOP** **Coverage not approved**
35. Is the patient currently receiving or has received in the last 6 months any immunotherapy (for example, OIT, SLIT, EPIT) to the food allergen being treated?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **36**
36. Is the patient currently receiving or has received in the last 6 months other immunomodulatory therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **37**
37. Does the provider acknowledge that the patient will continue to be counseled on the following: (1) the requested medication does not eliminate food allergy and the patient must continue to avoid food allergen; (2) the need for access to an epinephrine injector; (3) the requested medication is not intended to treat emergencies?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

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

Prescriber Signature ____________________ Date __________