TRICARE Prior Authorization Request Form for
omalizumab **(Xolair) syringe, autoinjector**

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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 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**

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

[14 August 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: