Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Xolair (omalizumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Xolair (omalizumab).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

If using for asthma:

1. Prescriber is a Pulmonologist or Allergist,
   □ No □ Yes

2. AND member has diagnosis of uncontrolled moderate to severe asthma defined as any of the following:
   a. ≥2 exacerbations in the past 12 months requiring systemic corticosteroids for more than 3 days
   b. ≥1 asthma exacerbation(s) leading to hospitalization in the past 12 months
   c. Dependence on daily oral corticosteroids (OCS) for asthma control
   d. Poor symptom control (ACT score less than 20)
   □ No □ Yes

3. AND member has uncontrolled asthma despite good adherence (at least 75% over the past 3 months) to a regimen containing: a high dose inhaled corticosteroid, long-acting beta 2 agonist, AND long-acting muscarinic antagonist, and consideration given to use of a leukotriene receptor antagonist,
   □ No □ Yes

4. AND member is ≥6 years,
   □ No □ Yes

5. AND clinical diagnosis of allergic asthma,
   □ No □ Yes

6. AND if requiring Xolair q2week dosing, patient has documented treatment failure, contraindication, or inadequate response to Dupixent,
   □ No □ Yes

7. AND Xolair will NOT be used with Fasenra (benralizumab), Cinqair (resilizumab), Nucala (mepolizumab), Dupixent (dupilumab), or Tezspire (tezepelumab-ekko)
   □ No □ Yes

If using for nasal polyps:

1. Prescriber is an Allergist or ENT Specialist,
   □ No □ Yes

2. AND member has diagnosis of rhinosinusitis with nasal polyps,
   □ No □ Yes

3. AND member has history of failure, inadequate response, contraindication, or intolerance to Dupixent (dupilumab)
   □ No □ Yes

If using for chronic spontaneous urticaria:

1. Prescriber is an Allergist or Dermatologist,
   □ No □ Yes

2. AND member has diagnosis of chronic spontaneous urticaria,
   □ No □ Yes

3. AND member is 12 years of age or older,
   □ No □ Yes

4. AND member has tried and failed therapy for a minimum of 4 weeks on ALL of the following, unless contraindicated:
    a. At least two different high-dose second generation H1-antihistamines (e.g. loratadine, cetirizine) 2-4 times normal dose daily OR two second-generation H1-antihistamines in combination (e.g. fexofenadine 180 mg daily in the morning plus cetirizine 10-20 mg daily at bedtime),
    b. AND montelukast in combination with a high-dose second generation H1-antihistamine,
    c. AND H2-antihistamines (e.g. famotidine, ranitidine) in combination with a high-dose second generation H1-antihistamine

    □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member has documentation of positive clinical response to Xolair therapy since last review
   □ No □ Yes

2. AND member continues to be under the care of a specialist
   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**