

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



6629

To be completed and signed by the prescriber.



Martin's Point

Clinical Documentation is required for a determination to be made.

Please fax completed form back to: (207) 828-7816

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

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

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

Step 2 Please complete the clinical assessment:

2	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	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No Proceed to question 7
	2. What is the indication or diagnosis?	<input type="checkbox"/> Asthma - Proceed to question 3 <input type="checkbox"/> Chronic rhinosinusitis with nasal polyposis - Proceed to question 4 <input type="checkbox"/> Chronic Idiopathic Urticaria (CIU) - Proceed to question 5 <input type="checkbox"/> Food allergy - Proceed to question 6 <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
	4. Is there evidence of effectiveness as documented by decrease in nasal polyps score or nasal congestion score?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Does the provider agree to ensure that the patient or caregiver is able to recognize symptoms of anaphylaxis?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP Coverage not approved
12. Is the patient currently receiving another immunobiologic (such as, benralizumab [Fasenra], mepolizumab [Nucala], or dupilumab [Dupixent])?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 13
13. What is the requested medication?	<input type="checkbox"/> XOLAIR Prefilled Syringe - Proceed to question 14 <input type="checkbox"/> XOLAIR Autoinjector - Proceed to question 15	
14. For XOLAIR Prefilled Syringe, provider acknowledges:	<input type="checkbox"/> Less than 1 years of age - Coverage not approved <input type="checkbox"/> Greater than or equal to 1 years of age and Less than 12 years of age: Administer by caregiver - Proceed to question 16 <input type="checkbox"/> 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	

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15. For XOLAIR Autoinjector, provider acknowledges:	<input type="checkbox"/> Less than 12 years of age - Coverage not approved <input type="checkbox"/> 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	
16. What is the indication or diagnosis?	<input type="checkbox"/> Asthma - Proceed to question 17 <input type="checkbox"/> Chronic rhinosinusitis with nasal polyposis - Proceed to question 21 <input type="checkbox"/> Chronic Idiopathic Urticaria (CIU) - Proceed to question 26 <input type="checkbox"/> Food allergy - Proceed to question 31 <input type="checkbox"/> Other - STOP Coverage not approved	
17. Is the patient 6 years of age or older?	<input type="checkbox"/> Yes Proceed to question 18	<input type="checkbox"/> No STOP Coverage not approved
18. Is the drug prescribed by an allergist, immunologist, pulmonologist, or asthma specialist?	<input type="checkbox"/> Yes Proceed to question 19	<input type="checkbox"/> No STOP Coverage not approved
19. Does the patient have moderate to severe asthma with baseline IgE levels that are greater than 30 IU/ml?	<input type="checkbox"/> Yes Proceed to question 20	<input type="checkbox"/> No STOP Coverage not approved
20. Has the patient tried and failed an adequate course (3 months) of two of the following while using a high-dose inhaled corticosteroid: <ul style="list-style-type: none"> • 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)? 	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
21. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 22	<input type="checkbox"/> No STOP Coverage not approved
22. Is the drug prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist?	<input type="checkbox"/> Yes Proceed to question 23	<input type="checkbox"/> No STOP Coverage not approved

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<p>23. Does the patient have chronic rhinosinusitis with nasal polyposis defined by all of the following:</p> <ul style="list-style-type: none"> • 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? 	<p><input type="checkbox"/> Yes Proceed to question 24</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>24. Will the requested medication only be used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation?</p>	<p><input type="checkbox"/> Yes Proceed to question 25</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>25. Do the symptoms of chronic rhinosinusitis with nasal polyposis continue to be inadequately controlled despite all of the following treatments:</p> <ul style="list-style-type: none"> • 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? 	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>26. Is the patient 12 years of age or older?</p>	<p><input type="checkbox"/> Yes Proceed to question 27</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>27. Is the drug prescribed by an allergist, immunologist, or dermatologist?</p>	<p><input type="checkbox"/> Yes Proceed to question 28</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>28. Is the requested medication being prescribed for chronic idiopathic urticarial and not for another form of urticaria?</p>	<p><input type="checkbox"/> Yes Proceed to question 29</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>29. Has the patient experienced symptoms for greater than 6 weeks?</p>	<p><input type="checkbox"/> Yes Proceed to question 30</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>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)?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>31. Is the drug prescribed by an allergist or immunologist?</p>	<p><input type="checkbox"/> Yes Proceed to question 32</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>32. Does the patient have a documented history of food allergy?</p>	<p><input type="checkbox"/> Yes Proceed to question 33</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>

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33. Is the patient currently receiving oral, IM, or IV corticosteroids, tricyclic antidepressants, or B-blockers (oral or topical)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 35 STOP Coverage not approved	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 36
36. Is the patient currently receiving or has received in the last 6 months other immunomodulatory therapy?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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]

Please attach office notes (clinical documentation)