Prescriber Criteria Form

Xolair 2025 PA Fax 473-A v2 010125.docx
Xolair (omalizumab)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xolair (omalizumab).

Drug Name:
Xolair (omalizumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of moderate to severe persistent asthma? [If no, then skip to question 9.]	Yes ◯	No ◯
2	Is the patient currently receiving treatment with the requested medication for asthma? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient's asthma control improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose? [If yes, then skip to question 8.] [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient had a positive skin test (or blood test) to at least one perennial aeroallergen? [If no, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a baseline immunoglobulin E (IgE) level greater than or equal to 30 international units (IU) per milliliter? [If no, then no further questions.]	Yes ◯	No ◯
6	Does the patient have inadequate asthma control despite current treatment with both of the following medications: A) medium-to-high-dose inhaled corticosteroid, B) additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene	Yes ◯	No ◯

	modifier, or sustained-release theophylline)? [If yes, then skip to question 8.]		
7	Does the patient have an intolerance or contraindication to both of the following therapies: A) medium-to-high-dose inhaled corticosteroid, B) additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? [If no, then no further questions.]	Yes ◯	No ◯
8	Is the patient 6 years of age or older? [No further questions.]	Yes ◯	No ◯
9	Does the patient have a diagnosis of chronic spontaneous urticaria (CSU)? [If no, then skip to question 17.]	Yes ◯	No ◯
10	Is the patient currently receiving treatment with the requested medication for chronic spontaneous urticaria (CSU)? [If no, then skip to question 13.]	Yes ◯	No ◯
11	Has the patient experienced a benefit (e.g., improved symptoms) since initiation of therapy? [If no, then no further questions.]	Yes ◯	No ◯
12	Is the patient 12 years of age or older? [No further questions.]	Yes ◯	No ◯
13	Has the patient been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1 (IL-1)-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis)? [If no, then no further questions.]	Yes ◯	No ◯
14	Has the patient experienced a spontaneous onset of wheals, angioedema, or both, for at least six weeks? [If no, then no further questions.]	Yes ◯	No ◯
15	Has the patient remained symptomatic despite H1 antihistamine treatment? [If no, then no further questions.]	Yes ◯	No ◯
16	Is the patient 12 years of age or older? [No further questions.]	Yes ◯	No ◯
17	Does the patient have a diagnosis of chronic nasosinusitis with nasal polyps (CRSwNP)? [If no, then skip to question 21.]	Yes ◯	No ◯
18	Will the requested drug be used as an add-on maintenance treatment? [If no, then no further questions.]	Yes ◯	No ◯
19	Has the patient experienced an inadequate treatment response to Xhance (fluticasone)? [If no, then no further questions.]	Yes ◯	No ◯

20	Is the patient 18 years of age or older? [No further questions.]	Yes ◯	No ◯
21	Does the patient have a diagnosis of immunoglobulin E (IgE)-mediated food allergy? [If no, then no further questions.]	Yes ◯	No ◯
22	Is the patient currently receiving treatment with the requested medication for immunoglobulin E (IgE)-mediated food allergy? [If yes, then skip to question 24.]	Yes ◯	No ◯
23	Does the patient have a baseline immunoglobulin E (IgE) level greater than or equal to 30 international units (IU) per milliliter? [If yes, then skip to question 25.] [If no, then no further questions.]	Yes ◯	No ◯
24	Has the patient experienced a benefit as evidenced by a decrease in hypersensitivity (e.g., moderate to severe skin, respiratory or gastrointestinal symptoms) to food allergen since initiation of therapy? [If no, then no further questions.]	Yes ◯	No ◯
25	Is the patient 1 year of age or older?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____