

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: Xolair[®] (omalizumab) (self-administered) (Pharmacy)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Quantity Limits: 1 syringe/auto-injector/vial per 28 days

- ☐ 75 mg/0.5 mL auto-injector
- ☐ 75 mg/0.5 mL prefilled syringe
- ☐ 150 mg/1 mL auto-injector
- ☐ 150 mg/1 mL prefilled syringe
- ☐ 150 mg/1.2 mL powder vial
- ☐ 300 mg/2 mL auto-injector
- ☐ 300 mg/2 mL prefilled syringe

*The Health Plan considers the use of concomitant therapy with Cinqair[®], Dupixent[®], Fasenra[®], Nucala[®], Tezspire[™] and Xolair[®] to be experimental and investigational. Safety and efficacy of these combinations have **NOT** been established and will **NOT** be permitted. In the event a member has an active Cinqair[®], Dupixent[®], Fasenra[®], Nucala[®] or Tezspire[™] authorization on file, all subsequent requests for Xolair[®] will **NOT** be approved.

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ **DIAGNOSIS: Moderate to Severe Persistent Asthma** – with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms are inadequately controlled with inhaled corticosteroids.

Initial Authorization: 12 months

Recommended Dosage: Maximum dosages will be based on a member weight of 150 kg.

Subcutaneous XOLAIR Doses Every 2 or 4 Weeks* for Patients 12 Years of Age and Older with Asthma

Pretreatment Serum IgE (IU/mL)	Dosing Freq.	Body Weight				
		30–60 kg	>60–70 kg	>70–90 kg	>90–150 kg	
		Dose (mg)				
≥30–100	Every	150	150	150	300	
>100–200	4	300	300	300	225	
>200–300	weeks	300	225	225	300	
>300–400	Every	225	225	300	Insufficient Data to Recommend a Dose	
>400–500	2	300	300	375		
>500–600	weeks	300	375	Insufficient Data to Recommend a Dose		
>600–700		375				

Subcutaneous XOLAIR Doses Every 2 or 4 Weeks* for Pediatric Patients with Asthma Who Begin XOLAIR Between the Ages of 6 to < 12 years

Pre-treatment Serum IgE (IU/mL)	Dosing Freq.	Body Weight										
		20-25 kg	>25-30 kg	>30-40 kg	>40-50 kg	>50-60 kg	>60-70 kg	>70-80 kg	>80-90 kg	>90-125 kg	>125-150 kg	
30-100 >100-200 >200-300 >300-400 >400-500 >500-600 >600-700 >700-800 >800-900 >900-1000 >1000-1100 >1100-1200 >1200-1300		Dose (mg)										
	Every 4 weeks	75	75	75	150	150	150	150	150	300	300	
		150	150	150	300	300	300	300	300	225	300	
		150	150	225	300	300	225	225	225	300	375	
		225	225	300	225	225	225	300	300			
		225	300	225	225	300	300	375	375			
		300	300	225	300	300	375					
		300	225	225	300	375						
	Every 2 weeks	225	225	300	375							
		225	225	300	375							
		225	300	375		Insufficient Data to Recommend a Dose						
		225	300	375		Insufficient Data to Recommend a Dose						
		300	300		Insufficient Data to Recommend a Dose							
300		375		Insufficient Data to Recommend a Dose								

(Continued on next page)

- ☐ Prescribed by or in consultation with an allergist, immunologist or pulmonologist
- ☐ Has the member been approved for Xolair® previously through AvMed Health Plans medical department?
 - ☐ Yes ☐ No
- ☐ Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications and must be compliant on therapy **for at least 90 consecutive days** within a year of request (**verified by pharmacy paid claims**):
 - ☐ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) **AND** an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
 - ☐ One maximally dosed combination ICS/LABA product (e.g., Advair® (fluticasone propionate/salmeterol), Dulera® (mometasone/formoterol), Symbicort® (budesonide/formoterol))
- ☐ Member must meet **ONE** of the following:
 - ☐ Member is ≥ 6 and < 12 years of age with a pre-treatment IgE level of 30-1300
 - ☐ Member is ≥ 12 years of age with a pre-treatment IgE level of 30-700

IgE level: _____ **Test Date:** _____
- ☐ Member has experienced **ONE** of the following (check box that applies):
 - ☐ **ONE (1)** or more exacerbations requiring additional medical treatment (e.g., oral corticosteroids, emergency department, urgent care visits or hospitalizations within the past 12 months)
 - ☐ Any prior intubation for an asthma exacerbation

☐ Diagnosis: Moderate-to-Severe Persistent Asthma

<u>Reauthorization: 12 months</u>
--

- ☐ Member has experienced a sustained positive clinical response to Xolair® therapy as demonstrated by at least **ONE** of the following (**check all that apply**):
 - ☐ Increase in percent predicted Forced Expiratory Volume (FEV1) from baseline (pre-treatment)
 - ☐ Reduction in the dose of inhaled corticosteroids required to control asthma
 - ☐ Reduction in the use of oral corticosteroids to treat/prevent exacerbation
 - ☐ Reduction in asthma symptoms such as chest tightness, coughing, shortness of breath or nocturnal awakenings
- ☐ Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications (**verified by pharmacy paid claims**):
 - ☐ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) **AND** an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
 - ☐ One maximally dosed combination ICS/LABA product (e.g., Advair® (fluticasone propionate/salmeterol), Dulera® (mometasone/formoterol), Symbicort® (budesonide/formoterol))

(Continued on next page)

☐ **DIAGNOSIS: Chronic Idiopathic Urticaria**

Initial Authorization: 12 months

Recommended Dosage: 150 mg or 300 mg by subcutaneous injection every 4 weeks

- ☐ Prescribed by or in consultation with an allergist or pulmonologist
- ☐ Member is > 12 years of age
- ☐ Member has had a confirmed diagnosis of chronic idiopathic urticaria for at least 6 weeks with or without angioedema
- ☐ Member has failed **ONE (1)** of the following H1 antihistamines at 4 times the initial dose for at least 4 weeks:

☐ levocetirizine 10 mg – 20 mg QD	☐ desloratadine 10 – 20 mg QD	☐ fexofenadine 120 mg – 240 mg BID
☐ cetirizine 20 mg – 40 mg QD	☐ loratadine 20 mg – 40 mg QD	

- ☐ Member has remained symptomatic despite treatment with **ALL** the following therapies (**verified by pharmacy paid claims**):
 - ☐ Hydroxyzine 10 mg – 25 mg taken daily
 - ☐ Leukotriene Antagonist for at least 4 weeks (e.g., montelukast, zafirlukast)
 - ☐ H2 antihistamine, for treatment of acute exacerbations, for at least 5 days (e.g., famotidine, cimetidine)

☐ **Diagnosis: Chronic Idiopathic Urticaria**

Reauthorization: 12 months

- ☐ Members disease status has been re-evaluated since the last authorization to confirm the members condition warrants continued treatment (**chart notes must be submitted for documentation**)
- ☐ Provider has submitted chart notes documenting the members symptoms have improved (e.g., a decrease in the number of hives, a decrease in the size of hives, and improvement of itching)
- ☐ Symptoms returned when the Xolair® dose was tapered or withheld beyond the next dosing interval (**chart notes must be submitted for documentation supporting tapering of dose and/or withholding of therapy beyond the next dosing interval to see if symptoms return**)

(Continued on next page)

❑ DIAGNOSIS: Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

Initial Authorization: 12 months

Recommended Dosage:

Pretreatment Serum IgE (IU/mL)	Dosing Freq.	Bodyweight							
		>30-40 kg	>40-50 kg	>50-60 kg	>60-70 kg	>70-80 kg	>80-90 kg	>90-125 kg	> 125-150 kg
		Dose (mg)							
30 - 100	Every 4 Weeks	75	150	150	150	150	150	300	300
>100 - 200		150	300	300	300	300	300	450	600
>200 - 300		225	300	300	450	450	450	600	375
>300 - 400		300	450	450	450	600	600	450	525
>400 - 500		450	450	600	600	375	375	525	600
>500 - 600		450	600	600	375	450	450	600	
>600 - 700		450	600	375	450	450	525		
>700 - 800	Every 2 Weeks	300	375	450	450	525	600		
>800 - 900		300	375	450	525	600			
>900 - 1000		375	450	525	600				
>1000 - 1100		375	450	600					
>1100 - 1200		450	525	600	Insufficient Data to Recommend a Dose				
>1200 - 1300		450	525						
>1300 - 1500		525	600						

- ❑ Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist
- ❑ Pre-treatment IgE level of 30-1500: _____ Test Date: _____
- ❑ Member is 18 years of age or older
- ❑ Member has a **diagnosis of CRSwNP** confirmed by the American Academy of Otolaryngology- Head and Neck Surgery Clinical Practice Guideline (Update): Adult Sinusitis (AAO-HNSF 2015)/American Academy of Allergy Asthma & Immunology (AAAAI) with **ONE** of the following clinical procedures:
 - ❑ Anterior rhinoscopy
 - ❑ Nasal endoscopy
 - ❑ Computed tomography (CT)

(Continued on next page)

- ☐ Member has a documented diagnosis of chronic rhinosinusitis defined by at least 12 weeks of the following:
 - ☐ Mucosal inflammation **AND** at least **TWO** of the following:
 - ☐ Decreased sense of smell
 - ☐ Facial pressure, pain, fullness
 - ☐ Mucopurulent drainage
 - ☐ Nasal obstruction
- ☐ Member has tried and failed intranasal corticosteroids **for at least 30 consecutive days** within a year of request (**verified by pharmacy paid claims**)
- ☐ Member is refractory, ineligible, or intolerant to **ONE** of the following:
 - ☐ Systemic corticosteroids
 - ☐ Sino-nasal surgery
- ☐ Member is requesting Xolair[®] (omalizumab) as add-on therapy to maintenance intranasal corticosteroids (**verified by pharmacy paid claims**)

☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

Reauthorization: 12 months

- ☐ Member has experienced a positive clinical response to Xolair[®] therapy (e.g., reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell, reduction in use of oral corticosteroids)
- ☐ Member has been compliant on Xolair[®] therapy and continues to receive therapy with an intranasal corticosteroid (**verified by pharmacy paid claims**)

(Continued on next page)

❑ DIAGNOSIS: Immunoglobulin (Ig) E-Mediated Food Allergy

Initial Authorization: 12 months

Recommended Dosage:

Pretreatment Serum IgE (IU/mL)	Dosing Freq.	Body Weight (kg)													
		≥10-12	>12-15	>15-20	>20-25	>25-30	>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	>90 - 125	>125 - 150	
		Dose (mg)													
≥30 - 100	Every 4 Weeks	75	75	75	75	75	75	150	150	150	150	150	300	300	
>100 - 200		75	75	75	150	150	150	300	300	300	300	300	450	600	
>200 - 300		75	75	150	150	150	225	300	300	450	450	450	600	375	
>300 - 400		150	150	150	225	225	300	450	450	450	600	600	450	525	
>400 - 500		150	150	225	225	300	450	450	600	600	375	375	525	600	
>500 - 600		150	150	225	300	300	450	600	600	375	450	450	600		
>600 - 700		150	150	225	300	225	450	600	375	450	450	525			
>700 - 800	Every 2 Weeks	150	150	150	225	225	300	375	450	450	525	600			
>800 - 900		150	150	150	225	225	300	375	450	525	600				
>900 - 1000		150	150	225	225	300	375	450	525	600					
>1000 - 1100		150	150	225	225	300	375	450	600	Insufficient data to Recommend a Dose					
>1100 - 1200		150	150	225	300	300	450	525	600						
>1200 - 1300		150	225	225	300	375	450	525							
>1300 - 1500		150	225	300	300	375	525	600							
>1500 - 1850			225	300	375	450	600								

- ❑ Member is ≥ 1 year of age
- ❑ Prescribed by or in consultation with an allergist or immunologist
- ❑ Member has a baseline immunoglobulin (Ig)E level ≥ 30 IU/mL - **Note: “Baseline” is defined as prior to receiving any treatment with Xolair® or another monoclonal antibody therapy that may lower IgE levels (e.g., Dupixent® [dupilumab subcutaneous injection], Tezspire™ [tezepelumab-ekko subcutaneous injection]).**
- ❑ Member must meet **BOTH** of the following:
 - ❑ Member has a positive skin prick test response to one or more foods
 - ❑ Member has a positive in vitro test (i.e., a blood test) for IgE to one or more foods

(Continued on next page)

- ☐ Provider attests member has a history of an allergic reaction to a food that met **ALL** the following:
 - ☐ Member demonstrated signs and symptoms of a significant systemic allergic reaction (e.g., hives, swelling, wheezing, hypotension, and gastrointestinal symptoms)
 - ☐ Reaction occurred within a short period of time following a known ingestion of the food
 - ☐ Prescriber deemed this reaction significant enough to require a prescription for an epinephrine auto-injector (e.g., EpiPen, EpiPen Jr., Auvi-Q, and generic epinephrine auto-injectors)
- ☐ Member has been prescribed an epinephrine auto-injector
- ☐ Provider attests Xolair® will be used in conjunction with a food allergen-avoidant diet
- ☐ Medication will **NOT** be used in conjunction with Palforzia® or oral immunotherapy (OIT)

☐ **DIAGNOSIS: Immunoglobulin (Ig) E-Mediated Food Allergy**

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member is compliant with Xolair® therapy
- ☐ Provider attests Xolair® will continue to be used in conjunction with a food allergen-avoidant diet
- ☐ Member has been prescribed an epinephrine auto-injector

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step-edit/ preauthorization criteria*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****