Pharmacy Prior Authorization

AETNA BETTER HEALTH LOUISIANA (MEDICAID)

Xolair (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Louisiana at **1-844-699-2889**.
When conditions are met, we will authorize the coverage of Xolair (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Xolair (omalizumab)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ ICD Code: _____

Circle the appropriate answer for each question.

1. Does the member have a diagnosis of moderate to severe persistent allergic asthma? Y N

   [If no, skip to question 4.]

2. Has the member been adherent to medication therapy, using proper inhaler technique (if applicable) and had an inadequate response to medium to high dose inhaled corticosteroids PLUS an inhaled long-acting beta agonist OR leukotriene modifier? Y N

   If yes, please document each medication and date range of treatment:
   _____

[If no, no further questions.]

3. Is the member 6 years of age or older on the date of the request? Y N

   [If yes, skip to question 7.]

   [If no, no further questions.]

4. Does the member have a diagnosis of chronic idiopathic urticaria? Y N

   [If no, no further questions.]

5. Has the member been adherent to H1 antihistamine therapy for a minimum of 4 weeks, but is still symptomatic? Y N

   If yes, please document each medication and date range of treatment:

   _____

   [If no, no further questions.]

6. Is the member 12 years of age or older on the date of the request? Y N

   [If no, no further questions.]

7. Based on the dosing tables in the prescribing information, are the requested dose and dosing frequency appropriate for the member's age, weight and pretreatment serum IgE level? Y N

   Please document the dates and results of the pre-treatment serum IgE level:

   _____

   [If no, no further questions.]

8. Has the prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements? Y N

   [If no, no further questions.]

9. Have all laboratory testing and clinical monitoring recommended in the prescribing information been completed as of the date of the request and will be repeated as recommended? Y N

   [If no, no further questions.]

10. Does the member have any inappropriate concomitant drug therapies or disease states? Y N

[If yes, no further questions.]

11. Has this plan authorized Xolair in the past for this member (i.e., previous authorization is on file under this plan)? Y N

    [If no, no further questions.]

12. Is there evidence of a positive response to therapy as indicated by improvement in signs, symptoms, and/or lab results compared to baseline? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date