

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

XOLAIR (omalizumab)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Minimum age requirement: 6 years old.
- Patient must have tried all other therapies for a time period generously adequate (at least 4 months) to establish indisputable failure of each.
- The request must include the following information:
 - Documentation of all failed therapies tried, and reason for requesting Xolair.
 - Include the desired starting dose of Xolair in the request.
 - Include the patient's baseline IgE value and weight in the written request.
- If requested for allergic asthma, please confirm that a skin test and/or in vitro reactivity test has/have been done.

NOTES:

- This medication is only payable through J-code J2357 to a physician's office. Patients with ACOs must make arrangements with their ACO for coverage.
- The patient must have regular appointments to receive the medication in the prescriber's office.
- The patient must remain in the office for a minimum of 90 minutes to allow for observation and treatment of anaphylaxis, if necessary.
- If/when any change of dose is requested, the prescriber must indicate, in writing, the reasoning for the dose increase.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Updated letter of medical necessity

12/5/2016

<https://medicaid.utah.gov/pharmacy/>