Xolair

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Site of Service Questions (SOS):

A. Indicate the site of service requested:

❑ On Campus Outpatient Hospital	❑ Off Campus Outpatient Hospital
❑ Home infusion, *skip to Criteria Questions*	❑ Physician office, *skip to Criteria Questions*
❑ Ambulatory surgical, *skip to Criteria Questions*	❑ Pharmacy, *skip to Criteria Questions*

B. Is this request to continue previously established treatment with the requested medication?
❑ Yes – This is a continuation of an existing treatment
❑ No – This is a new therapy request (patient has not received requested medication in the last 3 months). *Skip to Clinical Criteria Questions*

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

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 Xolair SOC SGM - 08/2021.

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

1. What is the diagnosis?
   ❑ Asthma
   ❑ Chronic idiopathic urticaria (CIU)
   ❑ Nasal polyps
   ❑ Other _____

2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Asthma

3. Will the patient receive Xolair as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? ❑ Yes ❑ No

4. Will the patient receive Xolair concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Nucala)? ❑ Yes ❑ No

5. Is the request for continuation of therapy with Xolair? ❑ Yes ❑ No *If No, skip to #8*

6. Is the patient currently receiving Xolair through samples or a manufacturer's patient assistance program?
   If Yes or Unknown, skip to #9 ❑ Yes ❑ No ❑ Unknown

7. Has the patient's asthma control improved on Xolair therapy as demonstrated by at least one of the following?
   Indicate below and no further questions.
   ❑ A reduction in the frequency or severity of symptoms and exacerbations
   ❑ A reduction in the daily maintenance oral corticosteroid dose
   ❑ None of the above

8. Does the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses?
   ❑ Yes ❑ No *Skip to #10*
   a) Inhaled corticosteroid
   b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)

9. Prior to receiving Xolair, did the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses?
   ❑ Yes ❑ No
   a) Inhaled corticosteroid
   b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)

10. Does the patient have positive skin test or *in vitro* reactivity to at least 1 perennial aeroallergen? ❑ Yes ❑ No

11. What is the patient's pre-treatment IgE level? ***ACTION REQUIRED: Please attach chart notes or medical record showing pre-treatment IgE level.*** _____ IU/mL ❑ No pre-treatment IgE level

Section B: Chronic Idiopathic Urticaria (CIU)

12. Is the request for continuation of therapy with Xolair? ❑ Yes ❑ No *If No, skip to #15*

13. Is the patient currently receiving Xolair through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #15* ❑ Yes ❑ No ❑ Unknown

14. Has the patient experienced a positive clinical response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy? ❑ Yes ❑ No *No further questions.*

15. How long has the patient had a spontaneous onset wheals and/or angioedema? _____ weeks.

16. Does the patient remain symptomatic despite treatment with a second-generation H1 antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine) for at least 2 weeks? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) documenting an inadequate symptomatic relief after at least 2 weeks of treatment with a second-generation H1 antihistamine.*** ❑ Yes ❑ No

17. Has the patient been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis)? ❑ Yes ❑ No

Section C: Nasal Polyps

18. Is the request for continuation of therapy with Xolair? ❑ Yes ❑ No *If No, skip to #21*

19. Is the patient currently receiving Xolair through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #21* ❑ Yes ❑ No ❑ Unknown

20. Has the patient experienced a response as evidenced by improvement in signs and symptoms (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, post-nasal drip)? ❑ Yes ❑ No *No further questions.*

21. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis? ❑ Yes ❑ No

22. Has the patient had intranasal corticosteroid treatment for at least 2 months? *If Yes, skip to #24* ❑ Yes ❑ No

23. Are intranasal corticosteroids contraindicated or not tolerated? ❑ Yes ❑ No

24. Has the patient had a bilateral nasal endoscopy or anterior rhinoscopy showing polys reaching below the lower border of the middle turbinate or beyond in each nostril? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record showing endoscopy or rhinoscopy details (e.g., polyps location, size).*** ❑ Yes ❑ No

25. Does the patient have nasal blockage? ❑ Yes ❑ No

26. Does the patient have rhinorrhea (anterior/posterior) or reduction or loss of smell? ❑ Yes ❑ No

27. Will the patient be using a daily intranasal corticosteroid while being treated with Xolair? *If Yes, no further questions* ❑ Yes ❑ No

28. Are intranasal corticosteroids contraindicated or not tolerated? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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