04/30/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Xolair (IL88)

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 Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xolair (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Xolair (omalizumab)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If yes, skip to question 12.]

2. Does the patient have a documented diagnosis of moderate to severe persistent asthma? Y N

   [If no, no further questions.]

3. Is Xolair prescribed by or after consultation with a pulmonologist or allergist? Y N

[If no, no further questions.]

4. Is the patient 12 years of age or older? Y N

   [If no, no further questions.]

5. Is the patient a non-smoker or actively receiving smoking cessation treatment? Y N

   [If no, no further questions.]

6. Does the patient weigh less than 150 kg (330 lbs)? Y N

   [If no, no further questions.]

7. Did the patient have baseline IgE levels between 30-700 IU/mL? If yes, please provide IgE level and date drawn: Y N

   _____

   [If no, no further questions.]

8. Did the patient have a positive skin test OR RAST (radioallergosorbent test) demonstrating in-vitro reactivity to at least one perennial aeroallergen? If yes, please provide test results and date obtained: Y N

   _____

   [If no, no further questions.]

9. Does the patient have forced expiratory volume in 1 second (FEV1) between 40% and 80% predicted? If yes, please provide date and FEV1 result: Y N

   _____

   [If no, no further questions.]

10. Does the patient have asthma symptoms that were not adequately controlled by a combination of the following agents for at least 4 consecutive months? Y N

    High dose inhaled corticosteroids (e.g., Pulmocort, Flovent, or combination agents Advair or Symbicort), AND \ Inhaled long-acting beta agonist (e.g., Serevent, Foradil, or combination agents Advair or Symbicort), AND \ A leukotriene receptor inhibitor (e.g., montelukast)

    [If no, no further questions.]

11. Have the patient's asthma symptoms been inadequately controlled as demonstrated by at least ONE of the following that is documented by medical records or by pharmacy claims history? If yes, please indicate all that Y N

apply to patient:

Requirement for systemic corticosteroids (e.g., oral prednisone/prednisolone, parenteral methylprednisolone) to treat asthma exacerbations OR \ 2 emergency department (ED) visits or hospitalization for asthma in the last 12 months (documented in medical records or database) OR \ Nighttime symptoms occurring more than once a week OR \ Daily use of rescue medications (short-acting inhaled beta-2 agonist such as ProAir, Proventil or Ventolin)

[No further questions.]

12. Has the patient experienced clinical improvement by demonstrating at least ONE of the following? If yes, please indicate all that apply to patient: Y N

    Decreased use of rescue medications OR \ Decreased use of systemic corticosteroids OR \ Improvement in FEV1 from pre-treatment baseline OR \ Reduction in number of ED visits or hospitalizations

    [If no, no further questions.]

13. Does the pharmacy claims history support that the patient is compliant with concurrent asthma medications (e.g., inhaled corticosteroid, long-acting beta agonist, leukotriene receptor inhibitor)? 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