Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Omalizumab (Xolair) – Medical Necessity Request

Complete page 1 and 2 for New/Initial requests

1. What is the prescriber's specialty? □ Allergy □ Pulmonology □ Dermatology □ Other: _____
2. Is the medication being administered in the physician's office? **Yes or No**
3. Will the member be concurrently receiving Xolair with Nucala, Cinqair or Fasenra? **Yes** or **No**
   - If yes, please provide drug name and reason why_____
4. What is the diagnosis?
   □ Urticaria
   a) Is the urticaria chronic (continuously or intermittently present for at least 6 weeks)? **Yes** or **No**
   b) Is the urticaria idiopathic (of unknown cause)? **Yes** or **No**
   c) Has member tried H1-antihistamine therapy? **Yes** Or **No**
      - If Yes, please provide drug name _____
        Dates filled _____
        (Please submit documentation e.g. copy of pharmacy claims, office notes)
   d) Has member tried another H1-antihistamine therapy? **Yes** or **No**
      - If Yes, please provide drug name_____
        Dates filled_____
        (Please submit documentation e.g. copy of pharmacy claims, office notes)
   e) Has member tried H2-antihistamine therapy? **Yes** or **No**
      - If Yes, please provide drug name _____
        Dates filled_____
        (Please submit documentation e.g. copy of pharmacy claims, office notes)
   f) Has member tried a leukotriene modifier (e.g. montelukast, or zafirlukast)? **Yes or No**
      - If Yes, please provide drug name _____
        Dates filled_____
        (Please submit documentation e.g. copy of pharmacy claims, office notes)
   g) Has member tried Hydroxyzine or doxepine? **Yes** or **No**
      - If Yes, please provide drug name _____
        Dates filled_____
        (Please submit documentation e.g. copy of pharmacy claims, office notes)
      - If No, Can member try at least one H1 anti-histamine together with another H1- antihistamine, H2-antagonist or a leukortriene receptor antagonist AND hydroxyzine or doxepine? **Yes** or **No**
        If No, please provide clinical reason_____
   g) Is the member symptomatic or refractory? **Yes** or No

□ Allergic Asthma (go to **Question #4**)

□ Asthma and Allergies (go to **Question #4)**

□ Asthma (Please answer the following and then go to **Question #4**)
- Is the asthma allergic? **Yes or No**
  - If not, does the member also have allergies? **Yes or No**

□ Allergies (Please answer the following and then go to **Question #4**)
- Does the member also have asthma? **Yes or No**

□ Other: _____

5. **For Allergic Asthma, Allergies, Asthma and Asthma and Allergies**
   A. Please indicate the severity of the asthma: □ mild □ moderate □ severe
   B. Is the Asthma persistent? **Yes** or **No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

C. Has the member received Xolair within the past year? **Yes** or **No**

D. What is the member's current weight? _____lbs Date Taken: _____
_____ kg

E. What was the member's pre-treatment IgE level (IU/ml)? _____

F. What is the current IgE level (IU/ml)? _____ Date Taken: _____

G. Has the member had a positive skin test or in vitro reactivity to a perennial aeroallergen (e.g. prick/puncture test, intracutaneous test, RAST)? **Yes** or **No**

H. Does member currently smoke? **Yes** or **No**

I. **For members 12 years of age or older**: Has member received high-dosed inhaled corticosteroid? **Yes** or **No**

- If yes: Please provide drug name _____
- Dose_____
- Dates filled_____
- ***(Please submit documentation e.g. copy of pharmacy claims, office notes)***

J. Has member received long-acting beta agonist (LABA) therapy? **Yes** or **No**

If yes, please provide drug name_____
Dates filled_____
(Please submit documentation e.g. copy of pharmacy claims, office notes)

If No, Can member try high dose inhaled corticosteroid together with LABA therapy? **Yes** or **No**
If No, please provide clinical reason_____

K. Answer following if member has not tried above drugs: Has member received medium to high-dosed inhaled corticosteroid? **Yes** or **No**

If yes, please provide drug name_____
Dose_____
Dates filled_____
(Please submit documentation e.g. copy of pharmacy claims, office notes)

L. Has member received Leukotriene modifier (e.g montelukast or zafirlukast)? **Yes** or **No**

If yes, please provide drug name_____
Dates filled_____
(Please submit documentation e.g. copy of pharmacy claims, office notes)

M. Has member received Theophylline? **Yes** or **No**

If yes, please provide drug name_____
Dates filled_____
(Please submit documentation e.g. copy of pharmacy claims, office notes)

N. Has member received Zileuton? **Yes** or **No**

If yes, please provide drug name_____
Dates filled_____
(Please submit documentation e.g. copy of pharmacy claims, office notes)

If No, Can member try medium to high-dosed inhaled corticosteroid together with Leukotriene modifier (e.g montelukast or zafirlukast), theophylline or zileuton? **Yes** or **No**
If No, please provide clinical reason_____

O. Has member been compliant? **Yes** or **No**

P. Is the member symptomatic or inadequately controlled? **Yes** or **No**

Q. For members 6 to 11 years of age: Has the member received a medium to high-dose inhaled corticosteroid? **Yes** or **No**

- If yes, Please provide drug name_____
  Dose_____
  Dates filled_____
  (Please submit documentation e.g. copy of pharmacy claims, office notes)
- If No, Can member try medium to high dose inhaled corticosteroid? **Yes** or **No**
- If No, please provide clinical reason_____

R. Has member been compliant? **Yes** or **No**

S. Is the member symptomatic or inadequately controlled? **Yes** or **No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Complete page 3 only for Subsequent/Renewal requests

1. What is the prescriber's specialty? □ Allergy □ Pulmonology □ Dermatology □ Other: _____
2. Is the medication being administered in the physician's office? **Yes or No**
3. Will the member be concurrently receiving Xolair with Nucala, Cinqair or Fasenra? **Yes** or **No**
   - If yes, please provide drug name and reason why_____
4. What is the diagnosis? **(please CHECK the member's diagnosis AND then answer the additional questions)**

Diagnosis	Additional Questions
□ Chronic Idiopathic Urticaria	Has the member responded to therapy by showing clinical improvement compared to pre-treatment? **Yes or No**
□ Allergic Asthma □ Allergies and Asthma □ Asthma □ Allergies	1. What is the member's current weight? _____lbs Date Taken: _____ _____ kg 2. What was the member's pre-treatment IgE level (IU/ml)? _____ 3. Has the member responded to therapy by showing clinical improvement and/or stable asthma control? **Yes or No** 4. Is the member currently smoking? **Yes or No**
□ Other _____	Please provide any additional clinical information pertaining to the request.

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**