

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for Xolair®. Payment for Xolair® will be authorized when the following criteria are met: **Moderate to Severe Persistent Asthma:** 1) Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and 2) Patient is 6 years of age or older; and 3) Medication is to be administered by a health care professional in the member's home by home health or in a long-term care facility; and 4) Pretreatment IgE level is within the following range: Adults and adolescent patients 12 years of age or older — 30 IU/mL to 700 IU/mL or pediatric patients 6 to less than 12 years of age — 30 IU/mL to 1300 IU/mL; and 5) Patient's weight is within the following range — Adults and adolescent patients 12 years of age or older 30 kg to 150 kg or pediatric patients 6 to less than 12 years of age — 20 kg to 150 kg; and 6) History of positive skin or RAST test to a perennial aeroallergen; and 7) Prescriber is an allergist, immunologist or pulmonologist; and 8) Patient is currently using a high dose inhaled corticosteroid, long-acting beta-agonist, AND leukotriene receptor antagonist, and is compliant with therapy and asthma symptoms are not adequately controlled after at least three months of therapy; and 9) Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. 10) Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of Xolair®. If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to Xolair® therapy and for patients who do not continue concurrent use with a high dose inhaled corticosteroid, long-acting beta-agonist, and leukotriene receptor antagonist. **Chronic Idiopathic Urticaria:** 1) Patient has a diagnosis of moderate to severe chronic urticaria; and 2) Patient is 12 years of age or older; and 3) Medication is to be administered by a health care professional in the member's home by home health or in a long-term care facility; and 4) Patient has documentation of a trial and therapy failure with at least one preferred second generation antihistamine, one of which must be cetirizine at a dose up to 20mg per day; and 5) Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and 6) Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and 7) Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second- generation antihistamine. If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult [www.iowamedicaidpdl.com/pa\\_criteria](http://www.iowamedicaidpdl.com/pa_criteria).

**Non-Preferred:**

Xolair

Strength: \_\_\_\_\_ Quantity: \_\_\_\_\_ Days supply: \_\_\_\_\_

Dosage instructions: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Please indicate setting in which Xolair is to be administered: \_\_\_\_\_

**Moderate to severe persistent asthma:**  Mild  Moderate  Severe

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**Inhaled corticosteroid trial:** Drug name:

Instructions:

Strength:

Trial date from:

Trial date to:

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**Inhaled Long-Acting Beta-Agonist trial:** Drug name:

Instructions:

Strength:

Trial date from:

Trial date to:

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**Leukotriene Receptor Antagonist trial:** Drug name:

Instructions:

Strength:

Trial date from:

Trial date to:

Medical or contraindication reason to override trial requirements:

**Pretreatment IgE level:**

Date obtained:

**Patient's Weight (kg):**

Date obtained:

**Is Xolair being dosed according to manufacturer labeling based on pretreatment serum IgE and body weight?:**

Yes  No

**History of positive skin or RAST test to a perennial aeroallergen:**  Yes  No Date performed:

**Please state prescriber's specialty:**

**Patient has access to epinephrine injection:**  Yes  No

**For Renewals Only: Has patient shown adequate response to Xolair® therapy?**  Yes  No

Please describe:

**Chronic idiopathic urticaria:**  Mild  Moderate  Severe

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**Preferred Second-Generation Antihistamine trial:** Drug name:

Dosing instructions:

Strength:

Trial date from:

Trial date to:

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**Preferred First-Generation Antihistamine trial:** Drug name:

Dosing instructions:

Strength:

Trial date from:

Trial date to:

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**Preferred Potent H1 receptor antagonist trial:** Drug name:

Dosing instructions:

Strength:

Trial date from:

Trial date to:

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**Preferred Leukotriene Receptor Antagonist in combination with a preferred first-or second- generation antihistamine:**

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**Preferred Leukotriene Receptor Antagonist trial:** Drug name:

Dosing instructions:

Strength:

Trial date from:

Trial date to:

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**Preferred First-or Second-Generation Antihistamine trial:** Drug name:

Dosing instructions:

Strength:

Trial date from:

Trial date to:

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**For renewal only: Has patient shown adequate response to Xolair® therapy:**  Yes  No

Please describe:

Medical or contraindication reason to override trial requirements:

**Attach lab results and other documentation as necessary.**

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature:  
(Must match prescriber listed above.)

Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check [www.amerihealthcaritasia.com/Provider](http://www.amerihealthcaritasia.com/Provider) to confirm your version of this form.