

Xolair® (omalizumab) Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: 1-866-752-7021 FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857 **FAX**: 1-844-268-7263

Please indicate: Start of treatment: Start date		☐ Continuation of therap	by: Date of las	st treatment _	/ /	
Precertification Requested By:		Phone:		Fax	:	
A. PATIENT INFORMATION						
First Name:	Last Name:			DOB:		
Address:		City:		State:	ZIP:	
Home Phone: Work Phone:		Cell Phone:		E-mail:		
Patient Current Weight: lbs or	kas Dationt Ho	I.	ome A	Allergies:		
-	_ kgs_Pallent ne	ightinches of	CITIS	allergies.		
B. INSURANCE INFORMATION	5 " 11					
		ave other coverage?				
Insured:	Insured:	#C	Jamei Name.			
Medicare: ☐ Yes ☐ No If yes, provide ID #:		Medicaid: Yes	No Ifves p	rovide ID #		
C. PRESCRIBER INFORMATION] . to y oo, p			
First Name:	Last Name:		(Check	(one)· □ M	I.D. 🗌 D.O. 🗌 N.P. 🔲	ТРΔ
Address:	Last Name.	City:	(Oncor	State:	ZIP:	J 1 ./\.
	St Lic #:	NPI#:	DEA #:		UPIN:	
			DEA #:			
Provider E-mail:	Office Contact N	ame:		Phon	e:	
Specialty (Check one): Allergist Pulmonologist	☐ ENT ☐ Pe	diatrician 🔲 Primary Car	re 🗌 Other:	!		
D. DISPENSING PROVIDER/ADMINISTRATION INFORM	MATION					
Place of Administration:		Dispensing Prov	/ider/Pharmac	y: (Patient s	elected choice)	
☐ Self-administered ☐ Physician's Office		☐ Physician's O		Retail Pharm		
☐ Outpatient Infusion Center Phone:		☐ Specialty Pha	armacy 🔲	Other:		
Center Name:		Name:				
Home Infusion Center Phone:		Address:				
Agency Name:					x:	
Address:		TIN:			N:	
E. PRODUCT INFORMATION						
		Frequency:				
Request is for: Xolair (omalizumab) Dose:		Frequency:				
Request is for: Xolair (omalizumab) Dose: F. DIAGNOSIS INFORMATION - Please indicate primary	ICD code and spec	ify any other where applicat	ble.	ada:		
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(All fields must be completed and legible for precertification review.)

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For Medicare Advantage Part B: Phone: 1-866-503-0857

1-844-268-7263

Patient First Name Patient Last Name Patient Phone Patient DOB G. CLINICAL INFORMATION (Continued) - Required clinical information must be completed for ALL precertification requests. Chronic idiopathic urticaria (CIU) Please indicate how long the patient had a spontaneous onset of wheals and/or angioedema (in weeks): Yes No Does the patient remain symptomatic despite treatment with a second-generation H1 antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine) for at least 2 weeks? ☐ Yes ☐ No 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)? Immune checkpoint inhibitor-related toxicity Yes No Does the patient have a refractory case of immune-therapy related severe (G3) pruritus? Yes No Does the patient have elevated IgE levels? Nasal polyps Yes No Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis? ☐ Yes ☐ No Has the patient had intranasal corticosteroid treatment for at least 2 months? → ☐ Yes ☐ No Are intranasal corticosteroids contraindicated or not tolerated? ☐ Yes ☐ No Has the patient had a bilateral nasal endoscopy or anterior rhinoscopy showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ☐ Yes ☐ No Does the patient have nasal blockage? ☐ Yes ☐ No Does the patient have rhinorrhea (anterior/posterior) or reduction or loss of smell? ☐ Yes ☐ No Will the patient be using a daily intranasal corticosteroid while being treated with the requested medication? → ☐ Yes ☐ No Are intranasal corticosteroids contraindicated or not tolerated? Systemic mastocytosis Please indicate which of the following diagnostic criterion for systemic mastocytosis is present: Major 2017 WHO Diagnostic criteria: ☐ Multifocal, dense infiltrates of mast cells (at least 15 mast cells in aggregates) detected in sections of bone marrow and/or other extracutaneous organs Minor 2017 WHO Diagnostic criteria: ☐ In biopsy sections of bone marrow or other extracutaneous organs, greater than 25% of mast cells in in the infiltrate are spindle-shaped or have atypical morphology of greater than 25% of all mast cells in bone marrow aspirate smears are immature or atypical Detection of an activating point mutation at codon 816 of KIT in the bone marrow, blood, or another extracutaneous organ Mast cells in bone marrow, blood, or other extracutaneous organs express CD25, with or without CD2, in addition to normal mast cell markers Serum total tryptase persistently greater than 20 ng/mL (unless there is an associated myeloid neoplasm, in which case this parameter is not valid) ■ None of the above Yes No Is the requested medication being prescribed as a step-wise prophylactic treatment for chronic mast cell mediator-related cardiovascular and pulmonary symptoms? → Yes □ No Is the requested medication being prescribed for prevention of recurrent unprovoked anaphylaxis? ⇒ ☐ Yes ☐ No Is the requested medication being prescribed for prevention of hymenoptera or food-induced anaphylaxis? ⇒ ☐ Yes ☐ No Is the requested medication being prescribed to improve tolerability of venom immunotherapy? → ☐ Yes ☐ No Does the patient have negative specific IgE or a negative skin test? → Please indicate which of the following the member has tried: ☐ H1 blockers and H2 blockers ☐ Corticosteroids ☐ None For Continuation Requests (clinical documentation required): ☐ Yes ☐ No Is this continuation request a result of the patient receiving samples or a manufacturer's patient assistance program? **Asthma** ☐ Yes ☐ No Has the patient's asthma control improved on the requested medication therapy as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? ☐ Yes ☐ No Has the patient's asthma control improved on the requested medication therapy as demonstrated by a reduction in the daily maintenance oral ☐ Yes ☐ No Will the patient receive the requested medication as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? ☐ Yes ☐ No Will the patient receive the requested medication concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Nucala)? Chronic idiopathic urticaria (CIU) ☐ Yes ☐ No Has the patient experienced a positive clinical response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy? Nasal polyps Yes No 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)? H. ACKNOWLEDGEMENT Request Completed By (Signature Required): Date: Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.