aetna℠

Omalizumab (Xolair®) Injectable Medication Precertification Request

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

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: ☐ **Start of treatment:** Start date ____/____/____ ☐ **Continuation of therapy:** Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Circle one):* M.D. D.O. N.P. P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Allergist** ☐ **Pulmonologist** ☐ **ENT** ☐ **Pediatrician** ☐ **Primary Care** ☐ **Other:** _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Xolair: Inject subcutaneously: ☐ **150 mg every 4 weeks** ☐ **300 mg every 4 weeks**
☐ **225 mg every 2 weeks** ☐ **300 mg every 2 weeks** ☐ **375 mg every 2 weeks** ☐ **Other dose/frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD-9 code and specify any other where applicable.

Primary ICD-9: _____ **Secondary ICD-9:** _____ **Other ICD-9 Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ASTHMA requests:

☐ Yes ☐ No Has the patient had moderate to severe persistent allergic asthma for at least 3 months?
☐ Yes ☐ No Have the patient's symptoms been inadequately controlled with a moderate dose of inhaled corticosteroids plus LABAs or leukotriene inhibitors for at least 3 months?

Specify the medications & dose: _____

☐ Yes ☐ No Does the patient have daily symptoms (e.g. coughing, wheezing, dyspnea) and/or exacerbations affecting activity and sleep?
☐ Yes ☐ No Did the patient have a positive skin or RAST test to a perennial aeroallergen?

Which of the following applies to the patient? *(Check all that apply)*
☐ Daily use of short-acting inhaled beta2-agonists?
☐ Diurnal variation in peak expiratory flow (PEF) of greater than 30%
☐ Forced expiratory volume in 1 second (FEV-1) less than 60% predicted
☐ PEF less than 80% of personal best
☐ A total of at least 3 of the following events within the preceding 12 months due to acute asthma exacerbations while on controller medications:
a) hospital admissions b) treatments with high-dose injectable or oral corticosteroids c) visits to the emergency room or urgent care center

Pretreatment Serum IgE Level (include unit of measure): _____ **Test Date:** ____/____/____

Current Weight (include unit of measure): _____ **Date Weight was taken**: ____/____/____

FOR CONTINUATION OF THERAPY – Please also complete the following questions
How long has the patient been on omalizumab (Xolair) therapy? _____

☐ Yes ☐ No Has the patient had decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids)?
☐ Yes ☐ No Has the patient had decreased utilization of rescue medications?
☐ Yes ☐ No Has the patient had an increase in percent predicted FEV-1 from pretreatment base line?
☐ Yes ☐ No Has the patient had a reduction in reported symptoms as evidenced by decreases in frequency or magnitude of one or more of the following symptoms: asthma attacks; chest tightness or heaviness; coughing or clearing throat; difficulty taking deep breath or difficulty breathing out; shortness of breath; sleep disturbance, night wakening, or symptoms upon awakening; tiredness; wheezing/heavy breathing/fighting for air?
☐ Yes ☐ No Has the patient experienced symptoms of anaphylaxis (bronchospasm, hypotension, syncope, urticaria, and/or angioedema) after administration of omalizumab (Xolair)?

For URTICARIA requests:

☐ Yes ☐ No Does the patient have moderate to severe chronic idiopathic urticaria and remains symptomatic despite H_1-antihistamine therapy?

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.