aetna®

Xolair® (omalizumab) 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
For Medicare Advantage Part B:
FAX: 1-844-268-7263

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:	E-mail:

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: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		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): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
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 code and specify any other where applicable.

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

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

For ASTHMA requests:

☐ Yes ☐ No Does the patient currently smoke?
→ ☐ Yes ☐ No Is the patient engaged in smoking cessation efforts?

☐ 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 Does the patient have a positive skin (e.g., prick/ puncture) or RAST test to a perennial aeroallergen?

☐ Yes ☐ No Does the patient use short-acting inhaled beta2-agonists daily?
→ Which of the following applies to the patient? *(Check all that apply)*
- ☐ 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

What is the patient's current weight and date obtained: _____lbs Date: ____/____/____
What is the patient's pretreatment serum IgE level and date obtained: IgE level: _____kU/L Date: ____/____/____
☐ Yes ☐ No Will the patient be taking Xolair in combination with Nucala or Cinqair?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For ASTHMA CONTINUATION OF THERAPY Requests *– Please also complete the following questions:*

How long has the patient been on omalizumab (Xolair) therapy? _____

☐ Yes ☐ No Is the patient on an asthma controller inhaler (e.g., inhaled corticosteroid with or without long-acting beta-2 agonist)?

→ ☐ Yes ☐ No Is an asthma controller inhaler contraindicated?

→ Please explain the contraindication: _____

→ Please provide the name of the medication: _____

☐ Yes ☐ No Has the patient shown clinical improvement with previous use of Xolair?

☐ 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 remain symptomatic despite therapy?

☐ Yes ☐ No Has the patient been treated with two or more H1 antihistamines?

→ How long was the treatment? ☐ Less than 2 weeks ☐ 2 weeks or longer

☐ Yes ☐ No Has the patient been treated with one H1 antihistamine AND one of the following:
☐ H2 antihistamines ☐ oral corticosteroids ☐ leukotriene modifiers?

→ How long was the treatment? ☐ Less than 2 weeks ☐ 2 weeks or longer

For *URTICARIA CONTINUATION OF THERAPY* Requests - *Please complete the following question:*

☐ Yes ☐ No Has the patient had an adequate response to Xolair?

☐ Yes ☐ No Has the patient experienced symptoms of anaphylaxis (bronchospasm, hypotension, syncope, urticaria, and/or angioedema) after administration of omalizumab (Xolair)?

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.