Arkansas Medicaid Prescription Drug Program

Statement of Medical Necessity for Xolair® (omalizumab) for Asthma

Fax form to Empower Healthcare Solutions 1-866-546-0484. For questions, call 1-844-865-7829.

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per beneficiary please. Information contained in this form is Protected Health Information under HIPAA and must come directly from the physician.

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Medicaid ID Number: _____ **Date of Birth:** _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI Number: _____ **Prescriber Specialty:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____

DRUG INFORMATION

Drug Name: Xolair **Drug Strength:** _____

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. All information must be provided; Arkansas Medicaid may verify through further requested documentation. The beneficiary's drug history will be reviewed prior to approval.

1. **Detailed description of diagnosis as per AHRQ National Guidelines:**

   _____

2. **Date diagnosed:** _____
3. **List daily standard controller medication(s), including prescribed dose, for the treatment of this diagnosis. The beneficiary's Medicaid drug profile will be reviewed to assist in verification of compliance. Physician must supply documentation of compliance to daily standard controller medication(s) if supplied by means other than Medicaid (samples, third party insurance, etc.). Minimum of 6 consecutive months of compliance on daily standard controller medication(s) is required.**

Drug Name: _____ **Drug Dose:** _____

Drug Name: _____ **Drug Dose:** _____

4. **Is a spacer for inhaled medications used?**

   ☐ **Yes** ☐ **No**

   If Yes, specify brand or type of spacer prescribed: _____

5. **Symptoms and Exacerbations listed below must have occurred while patient is compliant on daily standard controller medications.**

   List Frequency of Symptoms: _____ **Date symptoms last occurred:** _____

   List Frequency of Exacerbations – Number: _____ **Per:** _____

Beneficiary's Name: _____

DRUG INFORMATION (CONTINUED)

Date exacerbations last occurred: _____

List Frequency of Nocturnal Symptoms – Number: _____ **Per:** _____

Date nocturnal symptoms last occurred: _____

6. **Describe beneficiary's level of physical activity:** _____
7. **FEV1 or PEF:** _____ **% predicted; Date measured:** _____
8. **Does patient have food or peanut allergy?** ☐ **Yes** ☐ **No**
   If Yes, describe: _____
9. **List the specific perennial aeroallergen results from skin test (e.g., prick/puncture test) or blood test (e.g., RAST):** _____
10. **Patient's weight:** _____ **kg;**

‡Baseline IgE Level: _____ **IU/mL**

‡IgE levels are not applicable for PA renewal requests.

Xolair® Dose will be based on the Xolair Dosage and Administration Dosage Chart. The chart below is a combination of the 2-week and 4-week dosage schedules, which are provided in the Xolair package insert. For full prescribing information, please refer to the Xolair package insert.

Pre-treatment Serum IgE (IU/mL)	Dosing Frequency	Body weight (kg) for patients 6 to < 12 years of age									
		20–25	> 25–30	> 30–40	> 40–50	> 50–60	> 60–70	> 70–80	> 80–90	> 90–125	> 125–150
		Dose (mg)									
≥ 30–100	Administer every 4 weeks	75	75	75	150	150	150	150	150	300	300
> 100–200		150	150	150	300	300	300	300	300	225	300
> 200–300		150	150	225	300	300	225	225	225	300	375
> 300–400	Administer every 2 weeks	225	225	300	225	225	225	300	300		
> 400–500		225	300	225	225	300	300	375	375		
> 500–600		300	300	225	300	300	375				
> 600–700		300	225	225	300	375					
> 700–800		225	225	300	375						
> 800–900		225	225	300	375						
> 900–1000		225	300	375							
> 1000–1100		225	300	375							
> 1100–1200		300	300								
> 1200–1300		300	375								

Insufficient Data to Recommend a Dose

Pre-treatment Serum IgE (IU/mL)	Dosing Frequency	Body weight (kg) for patients ≥ 12 years of age			
		30–60	> 60–70	> 70–90	> 90–150
		Dose (mg)			
≥ 30–100	Administer every 4 weeks	150	150	150	300
> 100–200		300	300	300	225
> 200–300	Administer every 2 weeks	300	225	225	300
> 300–400		225	225	300	
> 400–500		300	300	375	
> 500–600		300	375		
> 600–700		375			

Insufficient Data to Recommend a Dose

Beneficiary's Name: _____

DRUG INFORMATION (CONTINUED)

11. Where will the medication be shipped (patient or physician)? _____

** **Please provide copies of medical documentation supporting the information above, including beneficiary's asthma management program and compliance plan.**

Prescriber Signature: _____ **Date:** _____

(Prescriber's original signature required; copied, stamped, or e-signature are not allowed. By signature, the physician confirms the above information is accurate and verifiable by patient records.)