CareSource PASSE

Arkansas Medicaid Prescription Drug Program
Statement of Medical Necessity for Xolair® (omalizumab)

After completing the information below, please fax to the CareSource PASSE Pharmacy Fax: 1-866-930-0019. For questions, call: 1-833-230-2100.

If the following information is not complete, correct or legible, the PA process can be delayed. Use one form per beneficiary please.

BENEFICIARY INFORMATION

BENEFICIARY LAST NAME:

BENEFICIARY FIRST NAME:

CARESOURCE PASSE ID NUMBER:

DATE OF BIRTH: – –

BENEFICIARY STREET ADDRESS:

CITY

STREET ADDRESS LINE 2:

STATE:

ZIP CODE:

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME:

PRESCRIBER FIRST NAME:

PRESCRIBER STREET ADDRESS:

CITY

STREET ADDRESS LINE 2:

STATE:

ZIP CODE:

NPI NUMBER:

DEA NUMBER:

PHONE NUMBER:

FAX NUMBER:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by CareSource PASSE.

All information must be provided and CareSource PASSE 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 (Please include ICD 10):

   _____

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 six consecutive months of compliance on daily standard controller medication(s) is required.

Drug	Dose	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: _____

   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)	Body Weight (kg)				
	30-60	>60-70	>70-90	>90-150	
≥ 30-100	150	150	150	300	Administration every 4 weeks
≥ 100-200	300	300	300	225	Administration every 2 weeks
≥ 200-300	300	225	225	300	
≥ 300-400	225	225	300	DO NOT DOSE	
≥ 400-500	300	300	375	DO NOT DOSE	
≥ 500-600	300	375	DO NOT DOSE	DO NOT DOSE	
≥ 600-700	375	DO NOT DOSE	DO NOT DOSE	DO NOT DOSE	

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

Specialty Pharmacy Name:	Specialty Pharmacy NPI:	Specialty Pharmacy Phone:

12. Physician's specialty: _____

The above format is to assist the physician in providing medical documentation that CareSource PASSE needs to review this request.
Information must come directly from the physician and will not be accepted from the pharmacy provider.
** Please provide copies of medical documentation supporting the information above, including beneficiary's asthma management program and compliance plan.

_____ _____

Prescriber Signature (Required) ***Date***

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