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

Upon completion, please fax this form to CareSource PASSE™ Pharmacy at **1-866-930-0019**.

Questions? Call CareSource PASSE Provider Services at **1-833-230-2100**, available Monday through Friday, 8 a.m. to 5 p.m. Central Time (CT).

Request Date: ☐☐ / ☐☐ / ☐☐☐☐ **Non-Urgent** ☐ **Urgent** ☐

Medication Start Date: ☐☐ / ☐☐ / ☐☐☐☐

****Incomplete or illegible information may delay processing****

Patient Information

Patient's First Name:	Patient's Last Name:
CareSource PASSE ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐
Patient Street Address:	City:
Street Address Line 2:	State: Zip Code:

Prescriber Information

Prescriber First Name:	Prescriber Last Name:
Prescriber Street Address:	City:
Street Address Line 2:	State: Zip Code:
NPI Number: ☐☐☐☐☐☐☐☐☐☐	DEA Number: ☐☐☐☐☐☐☐☐☐
Prescriber Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

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

All information must be provided and CaseSource PASSE may verify through further requested documentation. The patient's drug history will be reviewed prior to approval.

1. Please provide a detailed description of diagnosis and the tenth edition of the International Classification of Diseases (ICD-10) diagnosis code:

____

2. Date diagnosed: ☐☐ / ☐☐ / ☐☐☐☐

3. List daily standard controller medication(s), including prescribed dose, for the treatment of this diagnosis. The patient's Medicaid drug profile will be reviewed to assist in verification of compliance. The prescribing 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.

Medication	Dose	Medication	Dose

4. Is a spacer used 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 patient's level of physical activity: _____________________________________

7. FEV1 or PEF: _____________ % predicted; Date measured: ☐☐ / ☐☐ / ☐☐☐☐

8. Does patient have any food or peanut allergies? **Yes** ☐ **No** ☐

- If yes, please describe:

  ____

9. List the specific perennial aeroallergen results from skin test (e.g. prick/puncture test) or blood test (e.g. RAST):

____

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10. Patient’s weight: _____________ kg   Baseline IgE Level: ________ IU/ml

Note: 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		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	Administer every 2 weeks	225	225	300	375			Insufficient Data to Recommend a Dose			
> 800–900		225	225	300	375						
> 900–1000		225	300	375							
> 1000–1100		225	300	375							
> 1100–1200		300	300								
> 1200–1300		300	375								

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		300	225	225	300
> 300–400	Administer every 2 weeks	225	225	300	Insufficient Data to Recommend a Dose
> 400–500		300	300	375	
> 500–600		300	375		
> 600–700		375			

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

Specialty Pharmacy Name:	
Specialty Pharmacy National Provider Identifier (NPI) Number:	
Specialty Pharmacy Phone:	

12. Physician’s Specialty: ____

Note: Information must come directly from the physician. Information given from the pharmacy provider will not be accepted.

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

Prescriber Signature (Required):

____ **Date:** ___________________

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