Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Xolair
(omalizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Xolair 150mg vial ☐ Xolair 75mg/0.5ml syringe ☐ Xolair 150mg/ml syringe ☐ Xolair 300mg/2ml syringe
☐ Other (*please specify*):
Directions for use, dose, and quantity: Duration of therapy: Frequency of therapy:
J-Code: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Data:

What diagnosis is Xolair being used to treat?

☐ atopic dermatitis
☐ asthma
☐ chronic idiopathic urticaria (CIU, or chronic spontaneous urticaria)
☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
☐ eosinophilic gastroenteritis (EG), eosinophilic esophagitis (EE), or eosinophilic colitis
☐ Immunoglobulin (Ig)E-Mediated Food Allergy
☐ latex allergy in healthcare workers with occupational latex allergy
☐ Other (*please specify*):

Will the patient use the requested medication with another Monoclonal Antibody Therapy? Monoclonal antibody therapies are Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglys (lebrikizumab-lbkz SC injection), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto SC injection), Fasenra (benralizumab subcutaneous injection), Nucala (mepolizumab subcutaneous injection), or Teszpire (tezepelumab-ekko subcutaneous injection). ☐ Yes ☐ No

Please provide clinical support for continued use of this medication in combination with other monoclonal antibody therapy for your patient.

(if asthma, CRSwNP, or IgE Mediated Food Allergy) At baseline, did the patient have an immunoglobulin E (IgE) level greater than or equal to 30 IU/mL? Baseline is defined as prior to receiving any treatment with the requested medication or another monoclonal antibody therapy that may lower IgE levels (for example, Dupixent, Tezspire). ☐ Yes ☐ No

(if asthma) Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? ☐ Yes ☐ No

(if CIU) Is the requested medication being prescribed by, or in consultation with, an allergist, immunologist, or dermatologist? ☐ Yes ☐ No

(if CRSwNP) Is the requested medication being prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist (ear, nose, and throat [ENT] physician specialist)? ☐ Yes ☐ No

(if IgE Mediated Food Allergy) Is the requested medication prescribed by, or in consultation with, an allergist or an immunologist? ☐ Yes ☐ No

Is this an initial therapy, restarting therapy, or currently receiving with the requested medication? If your patient has been receiving samples, please choose initial therapy.

☐ Initial therapy
☐ Currently receiving the requested medication
☐ Restarting therapy

If currently receiving:

How many months of therapy with this medication has the patient received?

☐ less than 4 months OR if Chronic Rhinosinusitis with nasal polyps, less than 6 months
☐ 4 or more months OR if Chronic Rhinosinusitis with nasal polyps, 6 or more months

(if asthma, currently receiving) Will the patient continue to receive therapy with either one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler? ☐ Yes ☐ No

(if asthma, currently receiving) Has the patient responded to therapy as determined by the prescriber (Examples of a response include decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department/urgent care, or medical clinic visits due to asthma; decreased reliever/rescue medication use; and improved lung function parameters)? ☐ Yes ☐ No

(if CIU, currently receiving) Has the patient responded to therapy as determined by the prescriber (Examples of a response include decreased severity of itching, decreased number and/or size of hives)? ☐ Yes ☐ No

(if CRSwNP, currently receiving) Will the patient continue to receive therapy with an intranasal corticosteroid? ☐ Yes ☐ No

(if CRSwNP, currently receiving) Has the patient responded to therapy as determined by the prescriber (Examples of a response include reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, and/or improved sense of smell)? ☐ Yes ☐ No

If asthma and initial therapy, restarting therapy, or currently receiving less than 4 months of therapy:

Did/Does the patient have a forced expiratory volume in 1 second (FEV1) of less than 80% predicted? (Note: The reduced FEV1 should not be due to smoking-related chronic obstructive pulmonary disease. Also the above lung function criteria may be met at anytime prior to or during asthma treatment.) ☐ Yes ☐ No

(if yes) Did/Does the patient have an FEV1/forced vital capacity (FVC) of less than 0.80? (Note: The above lung function criteria may be met at anytime prior to or during asthma treatment.) ☐ Yes ☐ No

(if no, and age 6-11 years) Did/Does the patient have an increase of greater than 12% in FEV1 following the administration of a standard dose of a short-acting bronchodilator? (Note: The above lung function criteria may be met at anytime prior to or during asthma treatment.) ☐ Yes ☐ No

(if no, and age 6-11 years) Did/Does the patient have an increase of greater than 12% in FEV1 between prescriber visits? (Note: The above lung function criteria may be met at anytime prior to or during asthma treatment.) ☐ Yes ☐ No

(if no, and age 6-11 years) Did/Does the patient have an increase of greater than 12% in FEV1 from baseline to after at least 4 weeks of asthma treatment? (Note: The above lung function criteria may be met at anytime prior to or during asthma treatment.) ☐ Yes ☐ No

(if no FEV1/FVC less than 0.80, and age 12 years and older) Did/Does the patient have an increase of greater than 12% AND greater than 200 mL in FEV1 following the administration of a standard dose of a short-acting bronchodilator? (Note: The above lung function criteria may be met at anytime prior to or during asthma treatment.) ☐ Yes ☐ No

(if no, and age 12 years and older) Did/Does the patient have an increase of greater than 12% AND greater than 200 mL in FEV1 between prescriber visits? (Note: The above lung function criteria may be met at anytime prior to or during asthma treatment.) ☐ Yes ☐ No

(if no, and age 12 years and older) Did/Does the patient have an increase of greater than 12% AND greater than 200 mL in FEV1 from baseline to after at least 4 weeks of asthma treatment? (Note: The above lung function criteria may be met at anytime prior to or during asthma treatment.) ☐ Yes ☐ No

(if no) When the patient was diagnosed with asthma, did they have a positive exercise or bronchial challenge test? ☐ Yes ☐ No

Prior to receiving the requested medication or another monoclonal antibody therapy that may interfere with allergen testing (for example, Dupixent and Tezspire), did/does the patient have a positive skin test or in vitro (that is, a blood test) for allergen-specific immunoglobulin E (IgE) for one or more perennial aeroallergens and/or one or more seasonal aeroallergens (Examples of perennial aeroallergens are house dust mite, animal dander, cockroach, feathers, and mold spores. Examples of seasonal aeroallergens are grass, pollen, and weeds)? ☐ Yes ☐ No

Has the patient received at least 3 consecutive months of therapy with an inhaled medium- or high-dosed corticosteroid? ☐ Yes ☐ No

During the time the patient received the medium- or high-dosed inhaled corticosteroid, did the patient also receive at least 3 consecutive months of therapy with at least one additional asthma controller or asthma maintenance medication? Notes: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, and monoclonal antibody therapies for asthma (for example, Xolair, Cinqair [reslizumab intravenous infusion], Dupixent, Fasenra [benralizumab subcutaneous injection], Nucala [mepolizumab subcutaneous injection], and Tezspire). Use of a combination inhaler containing both a medium- or high-dose inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfill the requirement for both. ☐ Yes ☐ No

At baseline, did the patient experience two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Baseline is defined as prior to receiving the requested medication or another monoclonal antibody therapy for asthma (examples include Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair). ☐ Yes ☐ No

(if no) At baseline, did the patient experience one or more asthma exacerbation(s) requiring hospitalization, an emergency department visit, or an urgent care visit in the previous year? Baseline is defined as prior to receiving the requested medication or another monoclonal antibody therapy for asthma (examples include Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair). ☐ Yes ☐ No

(if no) At baseline, did/does the patient have asthma that worsens upon tapering of oral corticosteroid therapy? Note: Baseline is defined as prior to receiving the requested medication or another monoclonal antibody therapy for asthma (examples include Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair). ☐ Yes ☐ No

If Chronic Rhinosinusitis with Nasal Polyps and Initial Therapy, Restarting Therapy, or Currently Receiving for less than 6 months:

Does the patient have chronic rhinosinusitis with nasal polyps as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan? ☐ Yes ☐ No

Which of the following symptoms has the patient experienced for at least 6 months?
☐ Nasal congestion only
☐ Nasal discharge only
☐ Nasal obstruction only
☐ Reduction/Loss of smell only
☐ 2 or more of the above symptoms
☐ none of the above

Has the patient received an intranasal corticosteroid for at least 4 weeks? ☐ Yes ☐ No

(if yes) Does/Will the patient continue to receive therapy with an intranasal corticosteroid concomitantly with the requested medication? ☐ Yes ☐ No

Has the patient had prior surgery for nasal polyps? ☐ Yes ☐ No

(if no) Has the patient received at least one course of treatment with a systemic corticosteroid for 5 days or more within the previous two years? ☐ Yes ☐ No

(if no) Does the patient have a contraindication to systemic corticosteroid therapy? ☐ Yes ☐ No

If Chronic Idiopathic Urticaria (CIU) or chronic spontaneous urticaria and Initial Therapy, Restarting Therapy, or Currently Receiving for less than 4 months:

Prior to starting the requested medication, did/has the patient had urticaria with symptoms present for greater than 3 days per week, for greater than 6 weeks, despite daily non-sedating H1 antihistamine therapy with doses that have been titrated up to a maximum of four times the standard FDA-approved dose? Examples of non-sedating H1 antihistamine therapy are as follows: cetirizine, desloratadine, fexofenadine, levocetirizine, and loratadine. ☐ Yes ☐ No

If Immunoglobulin (Ig)E-Mediated Food Allergy:

Has the patient had a positive skin prick test (SPT) response to one or more foods? ☐ Yes ☐ No

Has the patient had a positive in vitro test (that is, a blood test) for IgE to one of more foods? ☐ Yes ☐ No

According to the prescriber, has the patient demonstrated signs and symptoms of a significant systemic allergic reaction? (Note: Signs and symptoms of a significant systemic allergic reaction include hives, swelling, wheezing, hypotension, and gastrointestinal symptoms). ☐ Yes ☐ No

(if yes) According to the prescriber, did this reaction occur within a short period of time following a known ingestion of the food? ☐ Yes ☐ No

(if yes) Has the prescriber deemed this reaction significant enough to require a prescription for an epinephrine auto-injector (Examples include EpiPen, EpiPen Jr., Auvi-Q, and generic epinephrine auto-injectors)? ☐ Yes ☐ No

Has the patient been prescribed an epinephrine auto-injector (Examples include EpiPen, EpiPen Jr., Auvi-Q, and generic epinephrine auto-injectors)? ☐ Yes ☐ No

Will the requested medication be used in conjunction with a food allergen-avoidant diet, according to the prescriber? ☐ Yes ☐ No

Additional Pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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