Xolair
(omalizumab)

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

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 or autoinjector
☐ Xolair 150mg/ml syringe or autoinjector
☐ Xolair 300mg/2ml syringe or autoinjector
☐ 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 Spontaneous Urticaria
☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
☐ eosinophilic gastroenteritis (EG), eosinophilic esophagitis (EE), or eosinophilic colitis
☐ Immunoglobulin (Ig)E-Mediated Food Allergy
☐ Treatment of latex allergy in healthcare workers with occupational latex allergy
☐ All other indications of diagnoses

Will Xolair be used in combination with another Monoclonal Antibody Therapy? Monoclonal antibody therapies are Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz SC injection), Exdensur (depemokimab-ulaa subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto SC injection), Nucala (mepolizumab subcutaneous injection), or Teszpire (tezepelumab-ekko subcutaneous injection). ☐ Yes ☐ No

(if asthma, CRSwNP, or IgE Mediated Food Allergy) Does the patient have a baseline immunoglobulin E (IgE) level greater than or equal to 30 IU/mL? Notes: Please Note: "Baseline" is defined as prior to receiving any treatment with Xolair or another monoclonal antibody therapy that may lower IgE levels (for example, Dupixent [dupilumab subcutaneous injection], Tezspire [tezepelumab-ekko subcutaneous injection]). ☐ Yes ☐ No

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

(if Chronic Spontaneous Urticaria) 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 the patient currently receiving Xolair? ☐ Yes ☐ No

<u>If currently receiving:</u>

(if asthma, currently receiving) Has the patient already received at least 4 months of therapy with Xolair? Please Note: Answer No if the patient has received less than 4 months of therapy or if the patient is restarting therapy with Xolair. ☐ Yes ☐ No

(if Chronic Spontaneous Urticaria, CRSwNP currently receiving) Has the patient already received at least 6 months of therapy with Xolair? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Xolair. ☐ Yes ☐ No

(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 prescriber determined that the patient has responded to therapy? Please Note: Examples of a response to Xolair therapy are 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 Chronic Spontaneous Urticaria, CRSwNP currently receiving) Has the patient already received at least 6 months of therapy with Xolair? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Xolair. ☐ Yes ☐ No

(if Chronic Spontaneous Urticaria, currently receiving) Has the patient experienced a beneficial clinical response, defined by one of the following: a. Decreased itch severity; b. Decreased number of hives; or c. Decreased 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 or equal to 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 or equal to 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 or equal to 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 or equal to 12% AND greater than or equal to 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 or equal to 12% AND greater than or equal to 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 or equal to 12% AND greater than or equal to 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 FEV1/FVC less than 0.8, AND no increase greater than or equal to 12% in FEV1 between prescriber visits/from baseline to after at least 4 weeks of asthma treatment) Did/Does the patient have a positive exercise challenge test? Note: The above lung function criteria may be met at anytime prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did/Does the patient have a positive bronchial challenge test? Note: The above lung function criteria may be met at anytime prior to or during asthma treatment. ☐ Yes ☐ No

Has the patient had a baseline positive skin test or in vitro test (that is, a blood test) for allergen-specific immunoglobulin E (IgE) for one or more perennial aeroallergens and/or for one or more seasonal aeroallergens? Notes: Please Note: "Baseline" is defined as prior to receiving any Xolair or another monoclonal antibody therapy that may interfere with allergen testing (for example, Dupixent and Tezspire). 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 combination therapy with BOTH of the following: an inhaled medium- or high-dose corticosteroid AND at least one additional asthma controller or asthma maintenance medication. Notes: Please Note: 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, Exdensur [depemokimab-ulaa subcutaneous injection], Fasenra [benralizumab subcutaneous injection], Nucala [mepolizumab subcutaneous injection], and Tezspire). Please Note: Use of a combination inhaler containing both a medium- or high- dose inhaled corticosteroid and additional asthma controller or asthma maintenance medication(s) would fulfil the requirement. ☐ Yes ☐ No

Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Notes: Please Note: "Baseline" is defined as prior to receiving Xolair or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Exdensur, Fasenra, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

(if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing one or more asthma exacerbation(s) requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous year? Notes: Please Note: "Baseline" is defined as prior to receiving Xolair or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Exdensur, Fasenra, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

(if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient having asthma that worsens upon tapering of oral corticosteroid therapy? Notes: Please Note: "Baseline" is defined as prior to receiving Xolair or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Exdensur, 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

Has the patient had the diagnosis of chronic rhinosinusitis with nasal polyps for at least 6 months? ☐ Yes ☐ No

Has the patient experienced TWO or more of the following symptoms for at least 8 weeks: nasal congestion, nasal obstruction, nasal discharge, and/or reduction/loss of smell? ☐ Yes ☐ No

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

(if yes) Will the patient continue to receive therapy with an intranasal corticosteroid concomitantly with Xolair? ☐ 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 within the previous year? Please note: One course of a systemic corticosteroid is greater than or equal to 3 consecutive days of treatment or one long-acting injectable dose. ☐ Yes ☐ No

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

If Chronic Spontaneous Urticaria and Initial Therapy, Restarting Therapy, or Currently Receiving for less than 6 months:

Has the patient had urticaria for greater than or equal to 6 weeks (prior to treatment with Xolair)? ☐ Yes ☐ No

According to the prescriber, has the patient tried high-dose oral second-generation H1 antihistamine therapy? Please Note: High-dose oral second-generation H1 antihistamine therapy is the highest dose tolerated by the patient and can be up to four times the FDA-approved dose. Examples of second-generation H1 antihistamines are 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

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

According to the prescriber, has the patient demonstrated signs and symptoms of a significant systemic allergic reaction to a food? (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 self-administered injectable or nasal product (Examples include EpiPen, EpiPen Jr., Auvi-Q, and generic epinephrine auto-injectors, and Neffy)? ☐ Yes ☐ No

Has the patient been prescribed an epinephrine self-administered injectable or nasal product (Examples include EpiPen, EpiPen Jr., Auvi-Q, and generic epinephrine auto-injectors, and Neffy)? ☐ Yes ☐ No

According to the prescriber, will Xolair be used in conjunction with a food allergen-avoidant diet? ☐ Yes ☐ No

Additional Pertinent Information:

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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