NEBRASKA MEDICAID & LONG-TERM CARE
Omalizumab (IgE) Blocker Therapy Prior Authorization Form

Member name:	Provider Name:
Member ID: DOB:	Provider number | NPI
Provider specialty:	Office phone: fax:

Please indicate: 'x' _□ Initial request or □ Renewal **HCPCS _____ Units _____**

Prior authorization indication: ' x' one of the following: □ Asthma □ Chronic Idiopathic Urticaria □ Nasal Polyps

ASTHMA:
The patient's submitted medical record documents **indicate that all** of the following criteria are met: The patient...

1. Is age 6 years or older; **and**
2. Has had moderate persistent or severe persistent asthma for at least 1 year (X all that apply);

and

Severe Persistent:	Moderate Persistent:
___ Continual symptoms; OR	___Daily symptoms (e.g. coughing, wheezing, dyspnea); OR
___Extremely limited physical activity; OR	___Exacerbation affects activity; OR
___Nighttime symptoms frequent; OR	___Nighttime symptoms > 1 time a week
___Daily use of inhaled short acting beta 2-agonist; OR	___Daily use of inhaled short acting beta 2-agonist; OR
___FEV1 or PEF < 60% predicted; OR	___PEF variability > 60% but < 80% predicted; OR
___FEV1/FVC is reduced greater than 5%	___FEV1 or FVC is reduced greater than 5%

3. Has evidence of specific allergic sensitivity, i.e, a positive skin test or in vitro reactivity to a perennial aeroallergen;
   TEST RESULT _____ Date _____; **and**
4. Has an IgE level of ≥ 30 IU/ml and ≤ 700; LEVEL _____ Date _____; **and**
5. Is ***inadequately*** controlled for 6 months despite use of standard therapies (circle one that applies):
   a. A combination of medium dose inhaled corticosteroid and a long-acting beta2 agonist inhaler; or a combination of a medium dose inhaled corticosteroid and a leukotriene inhibitor; **and** _____
6. Is ***also being treated*** with one of the following rescue medications due to inadequate control (circle one that applies):
   b. Frequent (2 or more episodes/week) use of a short acting beta2 agonist; or
   c. Use of high dose inhaled corticosteroids to maintain adequate control; or
   d. Frequent (4 or more per year) short courses of systemic corticosteroids (not oral steroid dependent) to maintain adequate control; **and**
7. Has been compliant with medication usage, peak flow monitoring, regular physician follow-up, and avoidance of triggering allergens as much as possible; **and**
8. Evaluation and medical records of the asthma specialist who is prescribing IgE blocker therapy are attached.

CHRONIC IDIOPATHIC URTICARIA (CIU):
The patient's submitted medical record documents **indicate that all** of the following criteria are met: The patient...

1. Is age 12 years or older; **and**
2. Has had moderate persistent or severe chronic idiopathic urticaria for at least 1 year; **and**
3. Prescribed by an Allergist, Immunologist, or Dermatologist (circle which applies); **and**
4. Documented failure of, or contraindication to, antihistamine, leukotriene inhibitor and immunosuppressive therapies; **and**
5. Evaluation and medical records of the specialist who is prescribing IgE blocker therapy are attached to include evidence of an evaluation that excludes other medical diagnoses associated with chronic idiopathic urticaria.

NASAL POLYPS:
The patient's submitted medical record documents **indicate that all** of the following criteria are met: The patient...

1. Is age 18 years or older; **and**
2. Has a diagnosis of nasal polyps by physical examination or diagnostic testing **and**
3. Symptoms are present e.g. nasal blockage, reduction or loss of smell, rhinorrhea, **and**
4. Xolair is prescribed by an Allergist, Immunologist, or Otolaryngologist (circle which applies); **and**
4. Failure of, or contraindication to, intranasal corticosteroids for at least 8 weeks, **and**
5. Concurrent use of intranasal corticosteroid with Xolair, unless contraindicated, is planned for maintenance therapy.

.Continued treatment authorization will be determined based on positive response to therapy.

DO NOT WRITE BELOW THIS LINE-MEDICAID USE ONLY:

_____Approval for Initiation of IgE Blocker Therapy for first 6 months from _____to_____.
(IgE blocker therapy that does not have a positive patient response after 3 months should be re-evaluated; treatment beyond 3 months with no improvement may not be covered by Medicaid)

_____Approval for on-going treatment for 12 months from _____ to _____.

_____ Denied. Rationale _____

_____

Signature_____**Date** _____
Medical director

Signature _____**Date** _____
Program specialist

Submit this form and medical records to Nebraska Medicaid Pharmacy Program Specialist by:
FAX: (402) 471-9092; EFAX to (402) 472-1104; or Mail at P.O. Box 95026, Lincoln, NE 68509

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