

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

Patient's Name \_\_\_\_\_

Medicaid ID: \_\_\_\_\_ Patient's date of birth: \_\_\_\_\_

Ordering Physician (please print) \_\_\_\_\_ Specialty \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Phone \_\_\_\_\_ Physician's Fax Number \_\_\_\_\_

Please indicate: \_\_\_\_\_ Initial request or \_\_\_\_\_ Subsequent request Asthma \_\_\_\_\_ or Chronic Idiopathic Urticaria \_\_\_\_\_

**ASTHMA:**

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

1. Is age 12 or older; **and**
2. Has had moderate persistent or severe persistent asthma for at least 1 year (X all that apply); **and**  

<u>Severe Persistent:</u> ____ Continual symptoms; OR ____ Extremely limited physical activity; OR ____ Nighttime symptoms frequent; OR ____ Daily use of inhaled short acting beta 2-agonist; OR ____ FEV1 or PEF < 60% predicted; OR ____ FEV1/FVC is reduced greater than 5%	<u>Moderate Persistent:</u> ____ Daily symptoms (e.g. coughing, wheezing, dyspnea); OR ____ Exacerbation affects activity; OR ____ Nighttime symptoms > 1 time a week ____ Daily use of inhaled short acting beta 2-agonist; OR ____ PEF variability > 60% but < 80% predicted; OR ____ 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  $\geq 30$  IU/ml and  $\leq 700$ ; LEVEL \_\_\_\_\_ Date \_\_\_\_\_; **and**
- \_\_\_\_ 5. Is inadequately controlled for 6 months despite use of standard therapies (circle one that applies):  
a. combination of medium dose inhaled corticosteroid and a long-acting beta2 agonist inhaler; or  
b. combination of 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):  
a. Frequent (2 or more episodes/week) use of a short acting beta2 agonist; or  
b. Use of high dose inhaled corticosteroids to maintain adequate control; or  
c. 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.

Any additional physician comments: \_\_\_\_\_

**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 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.

Any additional physician comments: \_\_\_\_\_

Ordering Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

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

**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 improve patient's asthma control after 3 months should be re-evaluated; treatment  
beyond 3 months with no improvement may not be covered by Medicaid)  
\_\_\_\_ Approval for Ongoing Therapy for 12 months from \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_ Denied/ Rationale \_\_\_\_\_  
\_\_\_\_ Unable to determine \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Medical director*

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Program specialist*