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 ☐ Other (*please specify*):

Directions for use, dose, and quantity: Duration of therapy:
J-Code: ICD10:

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

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

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?
☐ asthma ☐ chronic idiopathic urticaria (CIU) ☐ Other (*please specify*):

Is Xolair being used in combination with another monoclonal antibody, such as Cinqair, Dupixent, Fasenra, or Nucala?
☐ Yes ☐ No
Is this a new start of therapy or continuation of therapy? If your patient has already begun treatment with Xolair's Starter Program or was getting samples/using coupons, please choose new start of therapy. ☐ new start ☐ continued therapy

<u>If continued therapy:</u>
Does your patient have documented evidence of positive clinical response to Xolair therapy? (for example, reduced exacerbations)
☐ Yes ☐ No
(if no positive response) Please provide clinical support for continued use of Xolair:

(if continued therapy) Which best applies to your patient?
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
☐ other

(if continued therapy) Please provide the dates your patient received Xolair. _____

(if asthma and continued therapy) Has your patient continued to use any of the following while on Xolair therapy? Check all that apply.
☐ Advair, BREO ELLIPTA, Dulera, or Symbicort
☐ Aerospan, Alvesco, Asmanex, Flovent, Pulmicort, QVAR
☐ Foradil, montelukast (Singulair), Perforomist, Serevent, zafirlukast (Accolate), Zyflo/Zyflo CR
☐ none of the above

(if CIU and continued therapy) Does/Will your patient continue to use a second generation H1 antihistamine (like Zyrtec [cetirizine], Clarinex [desloratadine], and Allegra [fexofenadine]) WITH Xolair? ☐ Yes ☐ No

If asthma and new start or patient part of Starter Program or received samples/coupons:
Does your patient have pretreatment laboratory date showing IgE levels that are greater than 30 IU/ml? ☐ Yes ☐ No

Has your patient had a positive skin test or in-vitro reactivity to a perennial aeroallergen? ☐ Yes ☐ No

Was your patient's asthma inadequately controlled on a moderate dose of any of the following for at least 3 months: Advair, Breo Ellipta, Dulera, or Symbicort? ☐ Yes OR this patient is not a candidate to use these medications ☐ No

(if no) Was your patient's asthma inadequately controlled on a moderate dose of an inhaled corticosteroid (ICS) AND a controller medication for at least 3 months?
ICS products are: Aerospan, Alvesco, Arnuity Ellipta, Asmanex, budesonide (Pulmicort), Flovent, Qvar.
Controller medications are: Foradil, montelukast (Singulair), Perforomist, Serevent, zafirlukast (Accolate), Zyflo/Zyflo CR.
☐ Yes OR this patient is not a candidate to use these medications ☐ No

Will your patient continue to use any of the following while on Xolair therapy? Check all that apply.
☐ Advair, BREO ELLIPTA, Dulera, or Symbicort
☐ Aerospan, Alvesco, Asmanex, Flovent, Pulmicort, QVAR
☐ Foradil, montelukast (Singulair), Perforomist, Serevent, zafirlukast (Accolate), Zyflo/Zyflo CR
☐ none of the above
(if none of the above) Is your patient not a candidate for any of the listed medications? Please state which ones and why.

What other medications will your patient be using while on Xolair therapy?

If CIU and new start or patient part of Starter Program or received samples/coupons:
Has your patient had symptoms for greater than 6 weeks? ☐ Yes ☐ No

(if CIU and new start) Has your patient had failure or inadequate response, or documented intolerance to a second generation H1 antihistamine (for example, cetirizine, desloratadine, fexofenadine), including a trial at twice recommended dosing for at least 4 weeks? (Second generation H1 antihistamines TWICE recommended dosing for ages 12 and older are as follows: Allegra (fexofenadine) 360mg once daily or 120mg twice daily; Clarinex (desloratadine): 10mg once daily; and/or Zyrtec (cetirizine): 10 to 20mg once daily).
☐ Yes ☐ No

(if no AND CIU and new start) Is your patient able to try a second generation H1 antihistamine (for example, Zyrtec [cetirizine], Clarinex [desloratadine], Allegra [fexofenadine]), including a trial at twice recommended dosing for at least 4 weeks?

(if CIU and new start) Has your patient had failure or inadequate response, or documented intolerance to any of the following: H2 antagonist (for example, Pepcid [famotidine] or Zantac [ranitidine]) used concurrently with a high dose second generation H1 antihistamine (High dose is anything HIGHER than these doses: Allegra [fexofenadine]: 180 mg once daily or 60 mg twice daily; Clarinex [desloratadine]: 5 mg once daily; and/or Zyrtec [cetirizine]: 5 to 10 mg once daily)? ☐ Yes ☐ No

(if no AND CIU and new start) Is your patient able to try a H2 antagonist (for example, Pepcid [famotidine] or Zantac [ranitidine]) concurrently with a high dose second generation H1 antihistamine (for example, Zyrtec [cetirizine], Clarinex [desloratadine], Allegra [fexofenadine])? ☐ Yes ☐ No

What alternatives have been tried? Please include drug name and documented results of taking each drug, including any intolerances or adverse reactions your patient experienced.

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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