SoonerCare
Oklahoma Health Care Authority

Statement of Medical Necessity for Xolair® (Omalizumab): Asthma Diagnosis

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN INFORMATION	MEMBER INFORMATION
Physician Name:	Member ID Number:
Address:	Member Name:
City: State: Zip:	Address:
Phone: ( )	City: State: Zip:
Fax: ( )	Phone: ( )

Name of outpatient healthcare facility where Xolair® will be delivered to and administered at:
____

Compliance with all of the prior authorization criteria is a condition for payment for this drug by OHCA.

All information must be provided and OHCA may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

1. Detailed description of diagnosis: ____

2. Date diagnosed: ______________________

3. List daily medications and dose prescribed for the treatment of this diagnosis:

Drug/Dose: ________________________________ Drug/Dose: ________________________________

Drug/Dose: ________________________________ Drug/Dose: ________________________________

4. Was a spacer for inhaled medications used? ________ If 'No', why not? ______________________________

5. Compliant on daily inhaled corticosteroids for a minimum of 3 months prior to request? Yes_____ No_____

6. List frequency of: Exacerbations – Number _______ Per ______; AND Nightly Symptoms – Number _______ Per ______

7. List place and dates of asthma related hospitalizations and/or ER visits in the past 6 months:

____

8. Patients weight: ________ kg; Baseline IgE level: ________ IU/ml; Xolair Dose: ______________________

9. Asthma reaction due to food or peanut allergy? ______; Or List the perennial aeroallergen ________________

10. Prescriber specialty? ________________________________

The above format is to assist the physician in providing medical documentation that OHCA needs to review this request. This information should come directly from the prescriber and NOT the pharmacy provider.

**** Please provide copies of medical documentation supporting the information above.**

Prescriber Signature: ______________________________ Date: ____________________
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*