Arkansas Medicaid Prescription Drug Program
Statement of Medical Necessity for Xolair® (omalizumab)

After completing the information below please fax to the Arkansas Medicaid Pharmacy Program. Fax: 1-800-424-7976. For questions call: 1-800-424-7895.

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per beneficiary please.

Beneficiary Information

LAST NAME: | **FIRST NAME:**

MEDICAID ID NUMBER: | **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: | **FIRST NAME:**

NPI NUMBER: | **DEA NUMBER:**

PHONE NUMBER: – – | **FAX NUMBER:** – –

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid.

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

1. Detailed description of diagnosis as per AHRQ National Guidelines: ______
2. Date diagnosed: ______
3. List daily standard controller medication(s), including prescribed dose, for the treatment of this diagnosis.The beneficiary's Medicaid drug profile will be reviewed to assist in verification of compliance. Physician must supply documentation of compliance to daily standard controller medication(s) if supplied by means other than Medicaid (samples, third party insurance, etc.). Minimum of 6 consecutive months of compliance on daily standard controller medication(s) is required.

Drug	Dose	Drug	Dose

4. Is a spacer for inhaled medications used? ☐ Yes ☐ No If Yes, specify brand or type of spacer prescribed: ______
5. Symptoms and Exacerbations listed below must have occurred while patient is compliant on daily standard controller medications.

   List Frequency of Symptoms ______ Date symptoms last occurred: ______

   List Frequency of Exacerbations -- Number ______ Per ______

   Date exacerbations last occurred: ______

   List Frequency of Nocturnal Symptoms -- Number ______ Per ______

   Date nocturnal symptoms last occurred: ______
6. Describe beneficiary's level physical activity: ______
7. FEV1 or PEF: ______ % predicted; Date measured: ______
8. Does patient have food or peanut allergy? ☐ Yes ☐ No If yes, describe: ______
9. List the specific perennial aeroallergen results from skin test (e.g., prick/puncture test) or blood test (e.g., RAST): ______
10. Patient's weight: ______ kg ‡Baseline IgE Level: ______ IU/ml ‡IgE levels are not applicable for PA renewal requests.

(MMA Rev 08/25/2016)

Xolair Dose will be based on the Xolair Dosage and Administration Dosage Chart. The chart below is a combination of the 2-week and 4-week dosage schedules, which are provided in the Xolair package insert. For full prescribing information, please refer to the Xolair package insert.

Pre-treatment Serum IgE (IU/ml	Body Weight (kg)			
	30-60	**>60-70**	**>70-90**	**>90-150**
≥ 30-100	150	150	150	300
≥ 100-200	300	300	300	225
≥ 200-300	300	225	225	300
≥ 300-400	225	225	300	**DO NOT DOSE**
≥ 400-500	300	300	375	**DO NOT DOSE**
≥ 500-600	300	375	**DO NOT DOSE**	**DO NOT DOSE**
≥ 600-700	375	**DO NOT DOSE**	**DO NOT DOSE**	**DO NOT DOSE**

Administration every 4 weeks

Administration every 2 weeks

11. Where will the medication be shipped (patient or physician)?: ______________________

12. Physician's specialty? ______________________

The above format is to assist the physician in providing medical documentation that Arkansas Medicaid needs to review this request.

Information must come directly from the physician and will not be accepted from the pharmacy provider.

** Please provide copies of medical documentation supporting the information above, including beneficiary's asthma management program and compliance plan.

______________________ ______________________

Prescriber Signature (Required) ***Date***

Prescriber's original signature required; copied, stamped, or e-signature are not allowed.

By signature the physician confirms the criteria information above is accurate and verifiable in patient records.