Xolair

HMSA Medicare Advantage - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Xolair HMSAMED C26258-A – 01/2026.

Criteria Questions:

1. Is the patient currently receiving therapy with an omalizumab product?
❒ Yes, *Continue to #2*
❒ No, *Continue to #5*

2. What is the diagnosis?
❒ Allergic asthma, *Continue to #3*
❒ Chronic spontaneous urticaria (CSU), *Continue to #4*
❒ Chronic rhinosinusitis with nasal polyps (CRSwNP), *Continue to #3*
❒ IgE-mediated food allergy, *Continue to #4*
❒ Prophylaxis of seasonal or perennial allergic rhinitis, *Continue to #4*
❒ Latex allergy prophylaxis, *Continue to #4*
❒ Adjunct to immunotherapy, *Continue to #4*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to #4*
❒ Systemic mastocytosis, *Continue to #4*
❒ Other, *No Further Questions*

3. Will the patient use the requested drug concomitantly with other biologics indicated for asthma or chronic rhinosinusitis with nasal polyps (CRSwNP) (e.g., Cinqair, Dupixent, Fasenra, Nucala, Tezspire)?
❒ Yes, *Continue to #4*
❒ No, *Continue to #4*

4. Is the patient receiving benefit from therapy? ***If Yes, chart notes or medical record documentation supporting benefit from therapy must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. What is the diagnosis?
❒ Allergic asthma, *Continue to #6*
❒ Chronic spontaneous urticaria (CSU), *Continue to #20*
❒ Chronic rhinosinusitis with nasal polyps (CRSwNP), *Continue to #30*
❒ IgE-mediated food allergy, *Continue to #50*
❒ Prophylaxis of seasonal or perennial allergic rhinitis, *Continue to #60*
❒ Latex allergy prophylaxis, *Continue to #65*
❒ Adjunct to immunotherapy, *Continue to #70*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to #75*
❒ Systemic mastocytosis, *Continue to #80*
❒ Other, *No Further Questions*

Asthma

6. Does the patient have a positive skin test or in vitro reactivity to at least one perennial aeroallergen?
❒ Yes, *Continue to #7*
❒ No, *Continue to #7*

7. What is the patient's pre-treatment IgE level in IU/mL? ***Chart notes or medical record documentation of pre-treatment IgE level must be submitted upon request***
❒ 30 IU/mL or greater, *Continue to #8*
❒ Less than 30 IU/mL, *Continue to #8*

8. Does the patient have a history of moderate to severe asthma?

❒ Yes, *Continue to #9*
❒ No, *Continue to #9*

9. Is the patient using an inhaled corticosteroid at an optimized dose without adequate asthma control? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration must be submitted upon request***
❒ Yes, *Continue to #11*
❒ No, *Continue to #10*

10. Does the patient have a clinical reason to avoid therapy with an inhaled corticosteroid? ***(Please provide the clinical reason in the space provided.) If Yes, documentation of clinical reason to avoid therapy must be submitted upon request***
❒ Yes, *Continue to #11, Please provide Clinical Reason:*

_____

_____

❒ No, *Continue to #11*

11. Is the patient using one of the following medications at an optimized dose without adequate asthma control? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration must be submitted upon request***
❒ Long-acting beta2-agonist, *Continue to #13*
❒ Long-acting muscarinic antagonist, *Continue to #13*
❒ Leukotriene modifier, *Continue to #13*
❒ Sustained-release theophylline, *Continue to #13*
❒ None of the above, *Continue to #12*

12. Does the patient have a clinical reason to avoid therapy with these medications(i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? ***(Please provide the clinical reason in the space provided.) If Yes, documentation of clinical reason to avoid therapy must be submitted upon request***
❒ Yes, *Continue to #13, Please provide Clinical Reason:*

_____

_____

❒ No, *Continue to #13*

13. Will the patient use the requested drug concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Nucala, Tezspire)?
❒ Yes, *Continue to #14*
❒ No, *Continue to #14*

14. What is the patient's age?
❒ 6 years of age or older, *No Further Questions*
❒ Less than 6 years of age, *No Further Questions*

Chronic spontaneous urticaria (CSU)

20. Has the patient experienced a spontaneous onset of wheals (hives), angioedema, or both for at least 6 weeks?
❒ Yes, *Continue to #21*
❒ No, *Continue to #21*

21. Has the patient remained symptomatic despite treatment with a second generation H1 antihistamine (e.g., cetirizine,

fexofenadine, levocetirizine, loratadine) for at least 2 weeks? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried showing an inadequate response to a second-generation H1 antihistamine must be submitted upon request***
❒ Yes, *Continue to #22*
❒ No, *Continue to #22*

22. Has the patient been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1-associated urticarial syndromes (autoinflammatory disorders, urticarial vasculitis)?
❒ Yes, *Continue to #23*
❒ No, *Continue to #23*

23. What is the patient's age?
❒ 12 years of age or older, *No Further Questions*
❒ Less than 12 years of age, *No Further Questions*

Chronic rhinosinusitis with nasal polyps (CRSwNP)

30. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis?
❒ Yes, *Continue to #31*
❒ No, *Continue to #31*

31. Has the patient had intranasal corticosteroid treatment for at least 4 weeks? ***If Yes, chart notes, medical record documentation, or claims history of previous medications tried including response to therapy, must be submitted upon request***
❒ Yes, *Continue to #33*
❒ No, *Continue to #32*

32. Are intranasal corticosteroids contraindicated or not tolerated? ***If Yes, documentation of clinical reason to avoid therapy must be submitted upon request***
❒ Yes, *Continue to #33*
❒ No, *Continue to #33*

33. Has the patient had a bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ***If Yes, chart notes or medical record documentation showing nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) details (e.g., polyps location, size), must be submitted upon request***
❒ Yes, *Continue to #36*
❒ No, *Continue to #34*

34. Does the patient have a Meltzer Clinical Score of 2 or higher in both nostrils*?* ***If Yes, chart notes or medical record documentation showing Meltzer Clinical Score must be submitted upon request***
❒ Yes, *Continue to #36*
❒ No, *Continue to #35*

35. Does the patient have a total endoscopic nasal polyp score (NPS) of at least 5 with a minimum score of 2 for each nostril? ***If Yes, chart notes or medical record documentation showing endoscopic nasal polyp score (NPS) must be submitted upon request***
❒ Yes, *Continue to #36*
❒ No, *Continue to #36*

36. Does the patient have symptoms of nasal blockage, congestion, or obstruction?

❒ Yes, *Continue to #37*
❒ No, *Continue to #37*

37. Does the patient have rhinorrhea (anterior/posterior), reduction or loss of smell, or facial pain or pressure?
❒ Yes, *Continue to #38*
❒ No, *Continue to #38*

38. Will the patient continue to use a daily intranasal corticosteroid while being treated with the requested drug?
❒ Yes, *Continue to #40*
❒ No, *Continue to #39*

39. Are intranasal corticosteroids contraindicated or not tolerated?
❒ Yes, *Continue to #40*
❒ No, *Continue to #40*

40. Will the patient use the requested drug concomitantly with other biologics indicated for chronic rhinosinusitis with nasal polyps (CRSwNP) (e.g., Dupixent, Nucala)?
❒ Yes, *Continue to #41*
❒ No, *Continue to #41*

41. What is the patient's age?
❒ 18 years of age or older, *No Further Questions*
❒ Less than 18 years of age, *No Further Questions*

IgE-mediated food allergy

50. Has the patient's IgE-mediated food allergy been confirmed by a pre-treatment allergen-specific serum IgE level?
❒ Yes, *Continue to #51*
❒ No, *Continue to #52*

51. What is the patient's pre-treatment allergen-specific serum IgE level in IU/mL? ***Chart notes, medical record documentation, or laboratory tests showing pre-treatment allergen-specific serum IgE level must be submitted upon request.***
❒ 6 IU/mL or greater, *Continue to #54*
❒ Less than 6 IU/mL, *Continue to #52*

52. Has the patient's IgE-mediated food allergy been confirmed by a skin-prick test (SPC)?
❒ Yes, *Continue to #53*
❒ No, *Continue to #53*

53. What was the patient's wheal diameter from the skin-prick test (SPC)? ***Chart notes or medical record documentation showing wheal diameter must be submitted upon request.***
❒ 4 mm or greater, *Continue to #54*
❒ Less than 4 mm, *Continue to #54*

54. Has the patient had a positive physician controlled oral food challenge (e.g., moderate to severe skin, respiratory, or gastrointestinal [GI] symptoms)? ***If Yes, chart notes or medical record documentation showing a positive physician controlled oral food challenge must be submitted upon request.***
❒ Yes, *Continue to #56*
❒ No, *Continue to #55*

55. Does the patient have a history of a systemic reaction to a specific food? ***If Yes, chart notes or medical record documentation showing history of a systemic reaction to a specific food must be submitted upon request*.**
❒ Yes, *Continue to #56*
❒ No, *Continue to #56*

56. What is the patient's pre-treatment serum IgE level in IU/mL? ***Chart notes, medical record documentation, or laboratory tests of pre-treatment IgE level must be submitted upon request.***
❒ 30 IU/mL or greater, *Continue to #57*
❒ Less than 30 IU/mL, *Continue to #57*

57. Will the patient continue to maintain a food-allergen avoidance diet?
❒ Yes, *Continue to #58*
❒ No, *Continue to #58*

58. What is the patient's age?
❒ 1 year of age or older, *No Further Questions*
❒ Less than 1 year of age, *No Further Questions*

Prophylaxis of seasonal or perennial allergic rhinitis

60. Has the patient had inadequate symptom control despite therapy with a combination of intranasal steroids and an intranasal antihistamine? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Latex allergy prophylaxis

65. Does the patient have a proven latex allergy? ***If Yes, chart notes or medical record documentation of allergy must be submitted upon request***
❒ Yes, *Continue to #66*
❒ No, *Continue to #66*

66. Is the patient unable to avoid occupational latex (e.g., healthcare worker)? ***(Please provide the clinical reason in the space provided.)***
❒ Yes, Clinical reason:

_____
_____, *No Further Questions*
❒ No, *No Further Questions*

Adjunct to immunotherapy

70. Is the patient receiving immunotherapy for seasonal allergic rhinitis? ***If Yes chart notes or medical record documentation of immunotherapy use must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Immune checkpoint inhibitor-related toxicity

75. Does the patient have a refractory case of immune-therapy related severe (G3) pruritus with no response to gabapentinoids in one month?

❒ Yes, *Continue to #76*
❒ No, *Continue to #76*

76. Does the patient have elevated IgE levels? ***If Yes, chart notes or medical record documentation of pre-treatment IgE level must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Systemic Mastocytosis

80. Does the patient have the major and at least one minor diagnostic criterion for systemic mastocytosis present? ***If Yes, chart notes or medical record documentation supporting diagnosis must be submitted upon request.***
❒ Yes, *Continue to #82*
❒ No, *Continue to #81*

81. Does the patient have three or more minor diagnostic criteria for systemic mastocytosis present? ***If Yes, chart notes or medical record documentation supporting diagnosis must be submitted upon request.***
❒ Yes, *Continue to #82*
❒ No, *Continue to #82*

82. Is the requested drug being prescribed as a stepwise prophylactic treatment for chronic mast cell mediator-related cardiovascular and pulmonary symptoms?
❒ Yes, *Continue to #83*
❒ No, *Continue to #84*

83. Has the patient tried corticosteroids, H1 blockers, and H2 blockers? ***If Yes, chart notes, medical record documentation, or claims history of prerequisite therapies must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

84. Is the requested drug being prescribed for prevention of unprovoked anaphylaxis?
❒ Yes, *No Further Questions*
❒ No, *Continue to #85*

85. Is the requested drug being prescribed for prevention of hymenoptera or food-induced anaphylaxis?
❒ Yes, *Continue to #86*
❒ No, *Continue to #87*

86. Does the patient have negative specific IgE or a negative skin test?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

87. Is the requested drug being prescribed to improve tolerability of venom immunotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512