CareFirst
Family of health care plans

CVS caremark™

Xolair (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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.

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Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
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*

Criteria Questions:

1. What is the patient's diagnosis?
   ❑ Allergic asthma
   ❑ Chronic idiopathic urticaria (CIU)
   ❑ Other ____

2. What is the ICD-10 code? _________________

3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to diagnosis section.*

4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to diagnosis section and complete this form in its entirety.*

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Complete the following section based on the patient's diagnosis.

Section A: Allergic Asthma

6. Is this request for initial therapy or for continuation of therapy?
   ❑ Initial therapy with Xolair, *skip to #8*
   ❑ Continuation of therapy with Xolair

7. Has the patient's asthma control improved on Xolair therapy as demonstrated by at least ONE of the following? ***Indicate below or mark "None of the above" and no further questions.***
   ❑ A reduction in the frequency or severity of symptoms and exacerbations
   ❑ An improvement in FEV_1 since initiation of therapy
   ❑ A reduction in the daily maintenance oral corticosteroid dose
   ❑ None of the above

8. Does the patient have positive skin or *in vitro* reactivity to at least 1 perennial aeroallergen? ❑ Yes ❑ No

9. What is the patient's pre-treatment IgE level? _________________ IU/mL ❑ No pre-treatment IgE level

10. Does the patient have inadequate asthma control despite treatment with BOTH of the following medications at optimized doses? ❑ Yes ❑ No
    a) Inhaled corticosteroid
    b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)

Section B: Chronic Idiopathic Urticaria (CIU)

11. Is this request for initial therapy or for continuation of therapy?
    ❑ Initial therapy with Xolair, *skip to #13*
    ❑ Continuation of therapy with Xolair

12. Has the patient experienced a positive clinical response since initiation of therapy?
    ❑ Yes ❑ No *No further questions*

13. How long has the patient had a spontaneous onset wheals and/or angioedema? _________________ weeks

14. Has the patient been evaluated for other causes of urticaria? ❑ Yes ❑ No

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)**