Statement of Medical Necessity for Xolair: Chronic Idiopathic Urticaria Diagnosis

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN INFORMATION		
Physician Name:		
Address:		
City:	State:	Zip:
Phone:		
Fax:		

MEMBER INFORMATION		
Member ID Number:		
Member Name:		
Address:		
City:	State:	Zip:
Phone:		

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 and the member's drug history will be reviewed prior to approval.

1. Detailed description of diagnosis: _____

2. Date diagnosed: _____

3. Have other forms of urticaria been ruled out? Yes _____ No _____

4. Have other potential causes of urticaria been ruled out? Yes _____ No _____

5. Member's Urticaria Activity Score (UAS): _____

6. List medications, dose prescribed, and dates of use for the treatment of this diagnosis:

Drug/Dose/Dates of Use: _____ Drug/Dose/Dates of Use: _____

Drug/Dose/Dates of Use: _____ Drug/Dose/Dates of Use: _____

Drug/Dose/Dates of Use: _____ Drug/Dose/Dates of Use: _____

Drug/Dose/Dates of Use: _____ Drug/Dose/Dates of Use: _____

7. Compliant on above medications for duration of therapy listed? Yes _____ No _____

8. Xolair Dose:

☐ 150mg

☐ 300mg *(Not approved for initial dosing)*

9. Prescriber specialty? _____

The above format is to assist the physician to provide 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.)

http://www.okhca.org

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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