EXPRESS SCRIPTS®

Clear Print

Prior Authorization Request

XOLAIR, OMLYCLO (omalizumab)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:		Last Name:
Insurance Carrier Name/Number:		
Group Number:		Client ID:
Date of Birth (YYYY/MM/DD):		Relationship: ☐ Employee ☐ Spouse ☐ Dependent
Language: ☐ English ☐ French		Gender: ☐ Male ☐ Female
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

☐ XOLAIR ☐ OMLYCLO			☐ New request ☐ Renewal request*
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Allergic Asthma

- ☐ For the treatment of moderate to severe persistent allergic asthma, AND
- ☐ The patient is 6 years of age or older, AND
- ☐ The patient has a positive skin test or in vitro reactivity to perennial aeroallergen, AND
- ☐ The patient's symptoms are inadequately controlled with inhaled corticosteroids *(Please list prior therapies in the chart below)*, AND
- ☐ The patient has a total IgE level between 30 IU/mL and 700 IU/mL (72 ng/mL to 1680 ng/mL) at baseline if 12 years of age or older, OR
- ☐ The patient has a total IgE level between 30 IU/mL and 1300 IU/mL (72 ng/mL to 3120 ng/mL) at baseline if between 6 to 11 years of age

Chronic Rhinosinusitis with Nasal Polyposis

INITIAL

- ☐ For the treatment of severe chronic rhinosinusitis with nasal polyposis (CRSwNP) in an adult, AND
- ☐ The patient has a nasal polyp score (NPS) of 5 or greater, AND
- ☐ The patient has a nasal congestion (NC) score of 2 or greater, AND
- ☐ The patient has been treated with sinus surgery, OR
- ☐ The patient has had an inadequate response or documented intolerance to at least 2 nasal corticosteroids, and to an oral corticosteroid *(Please list prior therapies in the chart below)*

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduction in nasal polyp size, a reduction in nasal congestion, a reduced need for systemic corticosteroids)

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Chronic Idiopathic Urticaria

INITIAL – *6 month approval*

- ☐ For the treatment of chronic idiopathic urticaria (CIU), AND
- ☐ The patient is 12 years of age or older, AND
- ☐ The patient remains symptomatic despite H1 antihistamine treatment at a maximum-tolerated dose *(Please list prior therapies in the chart below)*

RENEWAL – *6 month approval*

- ☐ The patient has demonstrated a complete response lasting less than 12 weeks (urticaria activity score [UAS7] of 6 or less), OR
- ☐ The patient has demonstrated a partial response (UAS7 score reduction by at least 9.5 points from baseline value and the UAS7 remains greater than 6), OR
- ☐ The patient has demonstrated relapse after a complete response lasting 12 weeks or more, after which treatment has stopped and UAS7 score is 16 or greater

OR

- ☐ None of the above criteria applies.

Relevant additional information:

2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

3. Additional criteria for XOLAIR requests

- ☐ The patient is intolerant to, or had a confirmed adverse event with a biosimilar *(Please indicate in the chart above)*

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SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax: Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail: Express Scripts Canada Clinical Services
6985 Financial Drive, Suite 300
Mississauga, ON, L5N 0G3