

## PURPOSE OF THE POLICY

To establish guidelines to evaluate the appropriateness of use for Xolair®

## STATEMENT OF THE POLICY

Xolair® will be covered if the following criteria are met:  
Applies to new starts only for Medicare Part D members

## PROCEDURES

### 1. Criteria for use

- 1.1 All approved FDA indications not otherwise excluded from Part D
- 1.2 Patient age  $\geq 12$  **AND**
- 1.3 Prescribed by a physician specializing in Allergy or Pulmonary Medicine **AND**
- 1.4 Patient has at least 1 of the following criteria: FEV1 or PEF less than 80% predicted, PEF variability greater than 30%, and positive RAST Test, or baseline IGE serum level greater than or equal to 30IU/ml
- 1.5 Patient has tried and failed an inhaled corticosteroid product combined w a 2<sup>nd</sup> asthma controller such as a long acting beta2-agonist, or leukotriene modifier or required 2 or more pulses of an oral corticosteroid use in 1y for the treatment of an asthma attack.

## HISTORY

Sleung 4-1-04 – original

11/17/05 – Sleung, no changes

3/15/07-P&T Review no changes

1/20/08-Thowerton added for new starts only for Med D mbrs

1/1/09-Thowerton-P&T review no changes for Med D 2009

1/1/2010-Thowerton - P&T no changes

1/1/2011-Thowerton-P&T no chngs

1.1.2011-Thowerton- whole policy redone in accordance to the Dec CMS Outlier Justifications

1.1.2012-Thowerton-P&T no chngs