



# Xolair Prior Authorization Program Summary

## POLICY REVIEW CYCLE

**Effective Date**  
04-01-2026

**Date of Origin**

## POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Xolair	omalizumab subcutaneous soln auto-injector	150 MG/ML ; 300 MG/2ML ; 75 MG/0.5ML	M ; N ; O ; Y	N		
Xolair	omalizumab subcutaneous soln prefilled syringe	150 MG/ML ; 300 MG/2ML ; 75 MG/0.5ML	M ; N ; O ; Y	N		

## CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Xolair	omalizumab subcutaneous soln auto-injector	150 MG/ML ; 300 MG/2ML ; 75 MG/0.5ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Xolair	omalizumab subcutaneous soln prefilled syringe	150 MG/ML ; 300 MG/2ML ; 75 MG/0.5ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			2026 ; Topaz ; Whole Foods

## PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval		
	<p><b>Initial Evaluation</b></p> <p><b>Target Agent(s)</b> will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> <li>1. ONE of the following: <ol style="list-style-type: none"> <li>A. The requested agent is eligible for continuation of therapy AND the following: <table border="1" data-bbox="235 604 1230 680"> <tr> <td><b>Agents Eligible for Continuation of Therapy</b></td> </tr> <tr> <td>All target agents are eligible for continuation of therapy</td> </tr> </table> </li> </ol> </li> </ol> <li>B. BOTH of the following: <ol style="list-style-type: none"> <li>1. ONE of the following: <ol style="list-style-type: none"> <li>A. The patient has a diagnosis of moderate to severe persistent asthma AND ALL of the following: <ol style="list-style-type: none"> <li>1. If the patient is 6 to less than 12 years of age, then BOTH of the following: <ol style="list-style-type: none"> <li>A. The patient's pretreatment IgE level is 30 IU/mL to 1300 IU/mL <b>AND</b></li> <li>B. The patient's weight is 20 kg to 150 kg <b>AND</b></li> </ol> </li> <li>2. If the patient is 12 years of age or over, then BOTH of the following: <ol style="list-style-type: none"> <li>A. The patient's pretreatment IgE level is 30 IU/mL to 700 IU/mL <b>AND</b></li> <li>B. The patient's weight is 30 kg to 150 kg <b>AND</b></li> </ol> </li> <li>3. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen <b>AND</b></li> <li>4. ONE of the following: <ol style="list-style-type: none"> <li>A. The patient has a history of uncontrolled asthma while on asthma control therapy (e.g., inhaled corticosteroid [ICS]/long-acting beta-2 agonist [LABA] combination therapy) as demonstrated by ONE of the following: <ol style="list-style-type: none"> <li>1. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months <b>OR</b></li> <li>2. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months <b>OR</b></li> <li>3. Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered <b>OR</b></li> <li>4. Baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted <b>OR</b></li> </ol> </li> <li>B. The patient's medication history (excluding sample use) indicates use of a biologic immunomodulator agent that is FDA labeled or</li> </ol> </li> </ol> </li> </ol> </li> </ol> </li>	<b>Agents Eligible for Continuation of Therapy</b>	All target agents are eligible for continuation of therapy
<b>Agents Eligible for Continuation of Therapy</b>			
All target agents are eligible for continuation of therapy			

Module	Clinical Criteria for Approval
	<p style="text-align: center;">supported in compendia for the treatment of asthma within the past 12 months <b>OR</b></p> <p>B. The patient has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]) AND ALL of the following:</p> <ol style="list-style-type: none"> <li>1. The patient has had hives and itching for more than 6 weeks <b>AND</b></li> <li>2. The prescriber has evaluated the patient to determine if the patient is currently treated with medication known to cause or worsen urticaria (e.g., NSAIDs) in order to reduce urticaria risk AND</li> <li>3. The patient has ONE of the following: <ol style="list-style-type: none"> <li>A. Tried and had an inadequate response to the FDA labeled maximum dose of ONE second-generation H1-antihistamine (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) AND ONE of the following: <ol style="list-style-type: none"> <li>1. The patient has tried and had an inadequate response to a maximally tolerated dose of ONE second-generation H1-antihistamine titrated up to 4 times above the FDA labeled maximum dose after at least a 2-week duration of therapy <b>OR</b></li> <li>2. There is support that the patient cannot be treated with a second-generation H1-antihistamine at a dose above the FDA labeled maximum dose <b>OR</b></li> </ol> </li> <li>B. An intolerance or hypersensitivity to ONE second-generation H1-antihistamine <b>OR</b></li> <li>C. An FDA labeled contraindication to ALL second-generation H1-antihistamines <b>OR</b></li> </ol> </li> </ol> <p>C. The patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND ALL of the following:</p> <ol style="list-style-type: none"> <li>1. BOTH of the following: <ol style="list-style-type: none"> <li>A. The patient's pretreatment IgE level is 30 IU/mL to 1500 IU/mL <b>AND</b></li> <li>B. The patient's weight is 30 kg to 150 kg <b>AND</b></li> </ol> </li> <li>2. The patient has at least TWO of the following symptoms consistent with chronic rhinosinusitis (CRS): <ol style="list-style-type: none"> <li>A. Nasal discharge (rhinorrhea or post-nasal drainage)</li> <li>B. Nasal obstruction or congestion</li> <li>C. Loss or decreased sense of smell (hyposmia)</li> <li>D. Facial pressure or pain <b>AND</b></li> </ol> </li> <li>3. The patient has had symptoms consistent with chronic rhinosinusitis (CRS) for at least 12 consecutive weeks <b>AND</b></li> <li>4. The patient's diagnosis was confirmed by ONE of the following: <ol style="list-style-type: none"> <li>A. Anterior rhinoscopy <b>OR</b></li> <li>B. Nasal endoscopy <b>OR</b></li> <li>C. Computed tomography (CT) of the sinuses <b>AND</b></li> </ol> </li> <li>5. The patient has ONE of the following: <ol style="list-style-type: none"> <li>A. Tried and had an inadequate response to ONE intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) after at least a 4-week duration of therapy <b>OR</b></li> <li>B. An intolerance or hypersensitivity to ONE intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) <b>OR</b></li> </ol> </li> </ol>

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	<ul style="list-style-type: none"> <li>C. An FDA labeled contraindication to ALL intranasal corticosteroids <b>OR</b></li> <li>D. The patient has a diagnosis of IgE-mediated food allergy AND ALL of the following: <ul style="list-style-type: none"> <li>1. BOTH of the following: <ul style="list-style-type: none"> <li>A. The patient's pretreatment IgE level is 30 IU/mL to 1850 IU/mL <b>AND</b></li> <li>B. The patient's weight is 10 kg to 150 kg <b>AND</b></li> </ul> </li> <li>2. The patient has an IgE-mediated food allergy confirmed by an allergy diagnostic test (e.g., skin prick test, serum specific IgE test, oral food challenge) <b>AND</b></li> <li>3. The requested agent will NOT be used for the emergency treatment of allergic reactions, including anaphylaxis <b>OR</b></li> </ul> </li> <li>E. The patient has another FDA labeled indication for the requested agent and route of administration <b>AND</b></li> <li>2. If the patient has an FDA labeled indication, then ONE of the following: <ul style="list-style-type: none"> <li>A. The patient's age is within FDA labeling for the requested indication for the requested agent <b>OR</b></li> <li>B. There is support for using the requested agent for the patient's age for the requested indication <b>OR</b></li> </ul> </li> <li>C. The patient has another indication that is supported in compendia for the requested agent and route of administration <b>AND</b></li> </ul> <p>2. If the patient has a diagnosis of moderate to severe persistent asthma, then ALL of the following:</p> <ul style="list-style-type: none"> <li>A. ONE of the following: <ul style="list-style-type: none"> <li>1. The patient is NOT currently treated with a biologic immunomodulator agent that is FDA labeled or supported in compendia for the treatment of asthma (including the requested agent) AND is currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days [chart notes required] <b>OR</b></li> <li>2. The patient is currently treated with a biologic immunomodulator agent that is FDA labeled or supported in compendia for the treatment of asthma (including the requested agent) AND ONE of the following [chart notes required]: <ul style="list-style-type: none"> <li>A. The patient is currently treated with an inhaled corticosteroid for at least 3 months that is adequately dosed to control symptoms AND has been adherent for 90 days within the past 120 days <b>OR</b></li> <li>B. The patient is currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days <b>OR</b></li> </ul> </li> <li>3. The patient has an intolerance or hypersensitivity to ONE inhaled corticosteroid <b>OR</b></li> <li>4. The patient has an FDA labeled contraindication to ALL inhaled corticosteroids <b>AND</b></li> </ul> </li> <li>B. ONE of the following: <ul style="list-style-type: none"> <li>1. The patient is currently treated for at least 3 months AND has been adherent for 90 days within the past 120 days with ONE of the following [chart notes required]: <ul style="list-style-type: none"> <li>A. A long-acting beta-2 agonist (LABA) <b>OR</b></li> <li>B. A long-acting muscarinic antagonist (LAMA) <b>OR</b></li> <li>C. A leukotriene receptor antagonist (LTRA) <b>OR</b></li> <li>D. Theophylline <b>OR</b></li> </ul> </li> <li>2. The patient has an intolerance or hypersensitivity to ONE long-acting beta-2 agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist (LTRA), or theophylline <b>OR</b></li> <li>3. The patient has an FDA labeled contraindication to ALL long-acting beta-2 agonists (LABA) AND long-acting muscarinic antagonists (LAMA) <b>AND</b></li> </ul> </li> <li>C. The patient will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent <b>AND</b></li> </ul>

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	<p>D. The requested quantity (dose) is based on the patient’s pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 375 mg every 2 weeks <b>AND</b></p> <p>3. If the patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP), then ALL of the following:</p> <ul style="list-style-type: none"> <li>A. The patient is currently treated with standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) <b>AND</b></li> <li>B. The patient will continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent <b>AND</b></li> <li>C. The requested quantity (dose) is based on the patient’s pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 600 mg every 2 weeks <b>AND</b></li> </ul> <p>4. If the patient has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]), then BOTH of the following:</p> <ul style="list-style-type: none"> <li>A. ONE of the following: <ul style="list-style-type: none"> <li>1. BOTH of the following: <ul style="list-style-type: none"> <li>A. The patient is currently treated with second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) <b>AND</b></li> <li>B. The patient will continue second-generation H1-antihistamine therapy in combination with the requested agent <b>OR</b></li> </ul> </li> <li>2. The patient has an intolerance, hypersensitivity, or FDA labeled contraindication to ALL second-generation H1-antihistamines <b>AND</b></li> </ul> </li> <li>B. The requested quantity (dose) is within FDA labeling AND does NOT exceed 300 mg every 4 weeks <b>AND</b></li> </ul> <p>5. If the patient has a diagnosis of IgE-mediated food allergy, then ALL of the following:</p> <ul style="list-style-type: none"> <li>A. The patient will avoid known food allergens while treated with the requested agent <b>AND</b></li> <li>B. The patient has epinephrine on hand for emergency treatment <b>AND</b></li> <li>C. The requested quantity (dose) is based on the patient’s pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 600 mg every 2 weeks <b>AND</b></li> </ul> <p>6. If the patient has another FDA labeled indication for the requested agent, the requested quantity (dose) is within FDA labeling for the requested indication <b>AND</b></p> <p>7. If the patient has another indication that is supported in compendia for the requested agent, the requested quantity (dose) is supported in compendia for the requested indication <b>AND</b></p> <p>8. The prescriber is a specialist in the area of the patient’s diagnosis (e.g., asthma: allergist, immunologist, pulmonologist; CRSwNP: otolaryngologist, allergist, immunologist, pulmonologist; CSU: allergist, dermatologist, immunologist; IgE-mediated food allergy: allergist, immunologist), or the prescriber has consulted with a specialist in the area of the patient’s diagnosis <b>AND</b></p> <p>9. ONE of the following (Please refer to “Agents NOT to be used Concomitantly” table):</p> <ul style="list-style-type: none"> <li>A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) <b>OR</b></li> <li>B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following: <ul style="list-style-type: none"> <li>1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent <b>AND</b></li> <li>2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) <b>AND</b></li> </ul> </li> </ul> <p>10. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p><b>Compendia Allowed:</b> AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use</p> <p><b>Length of Approval:</b></p>

Module	Clinical Criteria for Approval
	<p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p><b>The requested agent will also be approved when ONE of the following is met:</b></p> <ol style="list-style-type: none"> <li>1. The request is for a BCBS MT Fully Insured or MT HIM member <b>AND</b> <ol style="list-style-type: none"> <li>A. The patient is under the age of 18 years old <b>AND</b></li> <li>B. The patient does NOT have any FDA labeled contraindications to the requested agent <b>AND</b></li> <li>C. The patient has an indication that is supported in TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <b>AND</b></li> <li>D. There is support for an age in the patient’s given age bracket in TWO articles from major peer-reviewed professional medical journals as generally safe and effective. The age brackets are: 1. infancy (birth up to, but not including, 2 years of age), 2. childhood (2 years of age through 11 years of age), 3. adolescence (12 years of age through 17 years of age). Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <b>OR</b></li> </ol> </li> <li>2. ALL of the following: <ol style="list-style-type: none"> <li>A. The member resides in Ohio <b>AND</b></li> <li>B. The plan is Fully Insured or HIM Shop (SG) <b>AND</b></li> <li>C. The patient does NOT have any FDA labeled contraindications to the requested agent <b>AND</b></li> <li>D. ONE of the following: <ol style="list-style-type: none"> <li>1. The patient has another FDA labeled indication for the requested agent and route of administration <b>OR</b></li> <li>2. The patient has another indication that is supported in compendia for the requested agent and route of administration <b>OR</b></li> <li>3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]</li> </ol> </li> </ol> </li> </ol> <p><b>Non-oncology compendia allowed:</b> DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p><b>Oncology compendia allowed:</b> NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p>

Module	Clinical Criteria for Approval
	<p data-bbox="232 180 500 210"><b>Renewal Evaluation</b></p> <p data-bbox="232 247 1081 277"><b>Target Agent(s)</b> will be approved when ALL of the following are met:</p> <ol data-bbox="280 315 1417 1990" style="list-style-type: none"> <li data-bbox="280 315 1417 401">1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) <b>AND</b></li> <li data-bbox="280 401 1417 1990">2. ONE of the following: <ol style="list-style-type: none"> <li data-bbox="375 432 1417 747">A. The patient has a diagnosis of moderate to severe persistent asthma <b>AND ALL</b> of the following: <ol style="list-style-type: none"> <li data-bbox="472 489 1417 518">1. The patient has had clinical benefit with the requested agent <b>AND</b></li> <li data-bbox="472 518 1417 659">2. The patient is currently treated within the past 90 days and is compliant with asthma control therapy (e.g., inhaled corticosteroids [ICS], ICS/long-acting beta-2 agonist [ICS/LABA], leukotriene receptor antagonist [LTRA], long-acting muscarinic antagonist [LAMA], theophylline) [chart notes required] <b>AND</b></li> <li data-bbox="472 659 1417 747">3. The requested quantity (dose) is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling <b>AND</b> does NOT exceed 375 mg every 2 weeks <b>OR</b></li> </ol> </li> <li data-bbox="375 747 1417 1037">B. The patient has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]) <b>AND ALL</b> of the following: <ol style="list-style-type: none"> <li data-bbox="472 804 1417 833">1. The patient has had clinical benefit with the requested agent <b>AND</b></li> <li data-bbox="472 833 1417 1037">2. ONE of the following: <ol style="list-style-type: none"> <li data-bbox="570 865 1417 978">A. The patient will continue second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) in combination with the requested agent <b>OR</b></li> <li data-bbox="570 978 1417 1037">B. The patient has an intolerance, hypersensitivity, or FDA labeled contraindication to ALL second-generation H1-antihistamines <b>AND</b></li> </ol> </li> <li data-bbox="472 1037 1417 1096">3. The requested quantity (dose) is within FDA labeling for the requested indication <b>AND</b> does NOT exceed 300 mg every 4 weeks <b>OR</b></li> </ol> </li> <li data-bbox="375 1096 1417 1383">C. The patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) <b>AND ALL</b> of the following: <ol style="list-style-type: none"> <li data-bbox="472 1155 1417 1184">1. The patient has had clinical benefit with the requested agent <b>AND</b></li> <li data-bbox="472 1184 1417 1297">2. The patient will continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent <b>AND</b></li> <li data-bbox="472 1297 1417 1383">3. The requested quantity (dose) is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling <b>AND</b> does NOT exceed 600 mg every 2 weeks <b>OR</b></li> </ol> </li> <li data-bbox="375 1383 1417 1614">D. The patient has a diagnosis of IgE-mediated food allergy <b>AND ALL</b> of the following: <ol style="list-style-type: none"> <li data-bbox="472 1442 1417 1501">1. The patient will avoid known food allergens while treated with the requested agent <b>AND</b></li> <li data-bbox="472 1501 1417 1530">2. The patient has epinephrine on hand for emergency treatment <b>AND</b></li> <li data-bbox="472 1530 1417 1614">3. The requested quantity (dose) is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling <b>AND</b> does NOT exceed 600 mg every 2 weeks <b>OR</b></li> </ol> </li> <li data-bbox="375 1614 1417 1755">E. The patient has a diagnosis other than moderate to severe persistent asthma, CSU/CIU, CRSwNP, or IgE-mediated food allergy <b>AND BOTH</b> of the following: <ol style="list-style-type: none"> <li data-bbox="472 1673 1417 1703">1. The patient has had clinical benefit with the requested agent <b>AND</b></li> <li data-bbox="472 1703 1417 1755">2. The requested quantity (dose) is within FDA labeling or supported in compendia for the requested indication <b>AND</b></li> </ol> </li> </ol> </li> <li data-bbox="280 1766 1417 1906">3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., asthma: allergist, immunologist, pulmonologist; CRSwNP: otolaryngologist, allergist, immunologist, pulmonologist; CSU: allergist, dermatologist, immunologist; IgE-mediated food allergy: allergist, immunologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis <b>AND</b></li> <li data-bbox="280 1906 1417 1990">4. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table): <ol style="list-style-type: none"> <li data-bbox="375 1938 1417 1990">A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) <b>OR</b></li> </ol> </li> </ol>

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	<p>B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following:</p> <ol style="list-style-type: none"> <li>1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent <b>AND</b></li> <li>2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) <b>AND</b></li> </ol> <p>5. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p>

## CONTRAINDICATION AGENTS

Contraindicated as Concomitant Therapy
<p><b>Agents NOT to be used Concomitantly</b></p> <p>Abrilada (adalimumab-afzb)  Actemra (tocilizumab)  Adalimumab  Adbry (tralokinumab-ldrm)  Amjevita (adalimumab-atto)  Arcalyst (rilonacept)  Avsola (infliximab-axxq)  Avtozma (tocilizumab-anoh)  Benlysta (belimumab)  Bimzelx (bimekizumab-bkzx)  Cibinqo (abrocitinib)  Cimzia (certolizumab)  Cinqair (reslizumab)  Cosentyx (secukinumab)  Cyltezo (adalimumab-adbm)  Dupixent (dupilumab)  Ebglyss (lebrikizumab-lbkz)  Enbrel (etanercept)  Entyvio (vedolizumab)  Fasenra (benralizumab)  Hadlima (adalimumab-bwwd)  Hulio (adalimumab-fkjp)  Humira (adalimumab)  Hyrimoz (adalimumab-adaz)  Idacio (adalimumab-aacf)  Ilaris (canakinumab)  Ilumya (tildrakizumab-asmn)  Imuldosa (ustekinumab-srlf)  Inflectra (infliximab-dyyb)  Infliximab  Kevzara (sarilumab)  Kineret (anakinra)  Leqselvi (deuruxolitinib)  Litfulo (ritlecitinib)  Nemluvio (nemolizumab-ilto)  Nucala (mepolizumab)  Olumiant (baricitinib)  Omlyclo (omalizumab-igec)  OmvoH (mirikizumab-mrkz)  Opzelura (ruxolitinib)</p>

**Contraindicated as Concomitant Therapy**

Orencia (abatacept)  
Otezla (apremilast)  
Otezla XR (apremilast extended-release)  
Otulfi (ustekinumab-aaaz)  
Pyzchiva (ustekinumab-ttwe)  
Remicade (infliximab)  
Renflexis (infliximab-abda)  
Rhapsido (remibrutinib)  
Riabni (rituximab-arrx)  
Rinvoq (upadacitinib)  
Rituxan (rituximab)  
Rituxan Hycela (rituximab/hyaluronidase human)  
Ruxience (rituximab-pvvr)  
Saphnelo (anifrolumab-fnia)  
Selarsdi (ustekinumab-aekn)  
Siliq (brodalumab)  
Simlandi (adalimumab-ryvk)  
Simponi (golimumab)  
Simponi ARIA (golimumab)  
Skyrizi (risankizumab-rzaa)  
Sotyktu (deucravacitinib)  
Spevigo (spesolimab-sbzo) subcutaneous injection  
Starjemza (ustekinumab-hmny)  
Stelara (ustekinumab)  
Steqeyma (ustekinumab-stba)  
Taltz (ixekizumab)  
Tezspire (tezepelumab-ekko)  
Tofidence (tocilizumab-bavi)  
Tremfya (guselkumab)  
Truxima (rituximab-abbs)  
Tyenne (tocilizumab-aazg)  
Tyruko (natalizumab-sztn)  
Tysabri (natalizumab)  
Ustekinumab  
Velsipity (etrasimod)  
Wezlana (ustekinumab-auub)  
Xeljanz (tofacitinib)  
Xeljanz XR (tofacitinib extended release)  
Xolair (omalizumab)  
Yesintek (ustekinumab-kfce)  
Yuflyma (adalimumab-aaty)  
Yusimry (adalimumab-aqvh)  
Zeposia (ozanimod)  
Zymfentra (infliximab-dyyb)