



Prior Authorization Form
Xolair® (omalizumab)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

[ ] Xolair®

Quantity \_\_\_\_\_ Refill x \_\_\_\_\_ months

Instructions \_\_\_\_\_

Physician's signature \_\_\_\_\_ Provider NPI: \_\_\_\_\_ MD# \_\_\_\_\_

Date: \_\_\_\_\_ Date medication needed \_\_\_\_\_

Patient Information

Patient's name \_\_\_\_\_

Patient's address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Patient's phone # \_\_\_\_\_

Patient's ID#: \_\_\_\_\_ DOB \_\_\_\_\_

Prescriber Information

Prescribing physician \_\_\_\_\_

Office address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office contact \_\_\_\_\_

Office # \_\_\_\_\_ Fax# \_\_\_\_\_

Upon approval, delivery is available. Complete section below.

[ ] No Delivery Requested

[ ] Delivery Requested

[ ] Physician's office

[ ] Patient's home

[ ] Member Pick up at pharmacy if benefit available

Preferred Vendor: \_\_\_\_\_

\*\*A copy of the prescription must accompany the medication request\*\*

1. PHYSICIAN'S SPECIALTY (required, specify all) \_\_\_\_\_

2. DIAGNOSIS FOR DRUG REQUESTED

[ ] Moderate to severe asthma

[ ] Other (specify) \_\_\_\_\_

3. PATIENT'S INFORMATION:

a. Has the patient had a positive skin test or in vitro reactivity to a perennial aeroallergen? [ ] Yes [ ] No [ ] N/A

b. Has the patient failed, is unresponsive to, or inadequately controlled on inhaled corticosteroids? [ ] Yes [ ] No [ ] N/A

c. Has the patient failed, is unresponsive to, or inadequately controlled on inhaled corticosteroids in combination with a long-acting beta agonist? [ ] Yes [ ] No [ ] N/A

d. Does the patient have a baseline serum IgE level between 30 IU/ml and 700 IU/ml? [ ] Yes [ ] No [ ] N/A

4. PATIENT HISTORY

[ ] New start [ ] Continued Treatment

Please list any previous or current therapies related to the diagnosis:

Table with 3 columns: Drug name, Dates, Duration

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only
Document #
M F Rx coverage Y N
Previous Auth Y N
Approved Reviewer Initials
Vendor
LOB
STANDARD - SELECT
Auth#
Date
Billing Code
Processor Initials
Date
From To
Coverage effective date / /