FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Xolair® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:
❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:
❑ Moderate to severe persistent asthma
❑ Chronic urticaria
❑ Other diagnosis: ____ ICD-10 Code(s): ________________________________

Prescriber's Specialty:
Select if the requested medication is prescribed by one of the following specialists:
❑ Allergist ❑ Dermatologist ❑ Immunologist ❑ Pulmonologist

For moderate to severe persistent asthma, answer the following:
Select if there is documentation the patient has the following:
❑ Positive skin test ❑ In vitro reactivity to a perennial aeroallergen
Is there documentation the patient has a baseline serum IgE level of between 30 IU/mL and 1300 IU/mL? ❑ **Yes** ❑ **No**
Is there documentation the patient has had an inadequate response or inability to tolerate a combination of high-dose inhaled corticosteroids (ICS) with a long-acting beta-agonist (LABA)? ❑ **Yes** ❑ **No**

For chronic urticaria, answer the following:
Is there documentation the patient had an inadequate response to or inability to tolerate one second-generation antihistamine at the maximum recommended doses? ❑ **Yes** ❑ **No**
Select if there is documentation the patient has had an inadequate response to or inability to tolerate the following:
❑ Leukotriene receptor antagonist (e.g., montelukast)
❑ Histamine H2-receptor antagonist (e.g., ranitidine, cimetidine, famotidine)
❑ Substituting to a different second-generation antihistamine
❑ Systemic glucocorticosteroids
❑ Cyclosporine

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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