

## Xolair® (omalizumab) Prior Authorization Request Form

Prior Authorization Request Form complete all fields and pre-Xolair® data column Fax this form with the patient completed

Health Impact Survey to: (716)-532-7360 or (800)-273-7397

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Last Name First Name			Member ID				Physician's Name (please print)				Physician's Signature		
Date of Birth	Sex □M Rac	е	Smoker? ☐ yes Weight ☐ no kg			T	Today's Date Phon			ne Nu	e Number Fax Number		
Xolair® dose requested:  ☐150 ☐300 mg/dose SC every 4 weeks -or- ☐225 ☐300 ☐375 mg/dose SC every 2 weeks					A	Address		City	/	State	Zip		
<ol> <li>Does patier</li> <li>If yes, is pa</li> <li>Have you re</li> <li>Has patient</li> <li>How long h</li> <li>Why do you sleep los exacerb</li> </ol> Lab Results	nt have moderate to severe astratient controlled according to NH equested and reviewed patient's needed systemic steroids in paras patient been under your care believe patient is a candidate that is a candidate for activity limitation ations requiring systemic steroid Serum IgE level:    Test date:   (Test date should be within last of Inhaled Corticosteroid (ICS)	BLI guidelines pharmacy cost 12 months processed all dis w/in past 1 L (KU/L) 2 months)	es? laims profile? s? <a href="mailto:3amos">3amos</a>	yes yes yes yes yes 12 mos heck all tha pulmona	no no no loo loo loo loo loo loo loo loo	8 9 1 pres sho	. Comorbidit . Duration of 0 Does patiel RAST?   coor compliant ow poor control  f ≥ class 2→ f ≥ 2+ →  Combination	ies: □COPI asthma?  Int have pet ir yes □no  ce w/ ICS ol MITE	D GERE O 19r O 19r O house to v O 6r O 6r O 78	D	specify specify  Oral steroid		
Therapy (check all that apply)	□beclomethasone 40, 80mcg □Flovent 44, 110, 220 mcg □Pulmicort □Azmacort		□Serevent □Foradil				Advair □100 mcg □250 mcg □500 mcg				provide dose:		
	Leukotriene Modifier  □Singular □Accolate		Short-acting Beta-agonist  □albuterol □Maxair				Other:  □Atrovent □Combivent				□Immunotherapy		
Complete 1st column only for prior authorization then other columns while on Xolair®  History (in last 4 weeks)  Frequency daytime symptoms (days/wk)  Frequency night-time symptoms (nights/wk) albuterol use (approx # puffs/day)  Days missed school/work  ER/Urgent Care/Hospital  Has controller medication use decreased?  Lung Function  Peak Flow Meter reading (today)  Best PFM reading @ home/ □ no PFM  FEV₁ (*required @ baseline & 6mos)  *Assessment  Health Impact survey  MD impression (better/ same/ worse)		I_I			16 weeksI  If Xolair® thera			Dateapdeo Rea  Medica Con ****** Dateapapded	Date received:approved expiration date:approved with modification _deniedother/No PA needed Reason:				
Medicatio	on ships to patient home on ships to provider office			1	<b>"</b>					Il Director, Independent Health	Date reviewed  Date reviewed		