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 Supply, authorization only [Flex series]**	☐ **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

b. Has the patient failed, is unresponsive to, or inadequately controlled on inhaled corticosteroids? ☐ Yes ☐ No

4. PATIENT HISTORY

☐ New start ☐ Continued Treatment

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

Drug name	Dates	Duration
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________

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

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FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only

Document #______________________ Vendor___________________ Billing Code______________ **M / Rx**

M F Rx coverage Y N LOB________________ Processor Initials____________

STANDARD - SELECT Date______________________

Previous Auth Y N Auth#______________________ From______________ To_____________

Approved **Reviewer Initials**______________ Date_______________Coverage effective date / /

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