AmeriHealth

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:
_____
_____
_____

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

Internal use only Vendor_____ Billing Code_____ **M / Rx**
Document #_____ LOB_____ Processor Initials_____
M F Rx coverage Y N STANDARD - SELECT Date_____
Previous Auth Y N Auth#_____ From_____ To_____
Approved **Reviewer Initials**_____ Date_____Coverage effective date / /