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	☐ 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:

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 #_________________________
M F Rx coverage Y N
Previous Auth Y N

Vendor____________________
LOB_________________
STANDARD - SELECT
Auth#______________________

Billing Code______________ **M / Rx**
Processor Initials___________
Date______________________
From______________ To_____________

AmeriHealth HMO, Inc. • AmeriHealth Insurance Company of New Jersey• QCC Insurance Company d/b/a AmeriHealth Insurance Company

Approved	**Reviewer Initials**______________	Date_______________	Coverage effective date / /