AmeriHealth

Today's date: _____ **Date medication needed:** _____

Prior Authorization Form - Xolair®

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Check one: ☐ New start ☐ Continued treatment

Patient information (please print)		**Physician information (please print)**	
Patient name		Prescribing physician	
Address		Office address	
City, state, ZIP		City, state, ZIP	
Patient telephone #		Office contact	
Patient ID		Office telephone #	
Date of Birth	Weight	Fax #	NPI

☐ **No delivery requested; physician will use office supply. Authorization only.**

☐ **Delivery requested to the physician's office.**

**** A copy of the prescription must accompany the medication request for delivery.****

1) Diagnosis for drug requested (must include ICD-10): _____

2) Patient medical information

For allergic asthma only:

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 high-dose inhaled corticosteroids in combination with a long-acting beta agonist? ☐ Yes ☐ No

c. Please fax baseline serum IgE level along with this form.

For chronic urticaria only:

a. Does the patient have a documented failure, contraindication, or intolerance to at least a 4-week trial of a second-generation non-sedating H1 antihistamine (e.g., Zyrtec®, Allegra®, Claritin®) at the maximum recommended dose? If yes, list the drug/dose/duration: _____ ☐ Yes ☐ No

b. Does the patient have a documented failure, contraindication, or intolerance to at least a 2-week trial of any of the drugs listed below? Check all that apply, and list the drug(s)/dosage(s)/duration(s) below: ☐ Yes ☐ No

- ☐ Leukotriene receptor antagonist (e.g., Singulair®); list drug/dose/duration: _____
- ☐ Histamine H2-receptor antagonist (e.g., Pepcid®, Zantac®); list drug/dose/duration: _____
- ☐ First-generation (sedating) H1 antihistamine (e.g., Benadryl); list drug/dose/duration: _____
- ☐ Systemic glucocorticosteroids administered as short-term therapy; list drug/dose/duration: _____
- ☐ Substitution to a different second-generation non-sedating H1 antihistamine; list drug/dose/duration: _____
- ☐ Cyclosporine, in addition to the non-sedating H1 antihistamine; list drug/dose/duration: _____

_____

3) Prescription information

Quantity _____ Refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature: _____

Please fax this completed form to 215-761-9580.