PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xolair

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?

- ☐ IgE-mediated allergic asthma
- ☐ Chronic idiopathic urticaria
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Has the diagnosis been confirmed by an allergist within the prior year?

☐ Yes ☐ No

Q4. Is the patient following allergen and irritant avoidance?

- ☐ Yes
- ☐ No
- ☐ Not applicable - not a contributing factor to asthma or urticaria

Q5. If the diagnosis is chronic idiopathic urticaria, does the patient continue to be symptomatic despite H1 anithistamine therapy?

☐ Yes ☐ No

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Q6. If the diagnosis is IgE-mediated allergic asthma, what is the patient's baseline IgE level?

Q7. If the diagnosis is IgE-mediated allergic asthma, what is the expected dose of Xolair?

Q8. Is Xolair used as adjunct and not replacing immunotherapy or other forms of treatment in this patient?

☐ Yes ☐ No

Q9. Is the patient demonstrably complying with full controller pharmacotherapy including combined inhaled corticosteroid and long-acting bronchodilator therapy?

☐ Yes ☐ No

Q10. Will the dose of Xolair first be reduced or discontinued when this patient becomes well-controlled?

☐ Yes ☐ No

Q11. Please indicate how poor control is demonstrated in this patient (please choose one of the following):

☐ One hospital admission in the prior six months
☐ Two emergency room or urgent care visits in the prior six months
☐ Two months of daily oral corticosteroid use without significant tapering
☐ Other events which are felt to indicate poor control (if option this is chosen, please elaborate in the Additional Comment field)
☐ None of the above

Q12. Has patient had a pulmonary profile has demonstrated evidence of reversible airways obstruction within the prior year?

☐ Yes ☐ No

Q13. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q14. Provide name and NPI of the billing entity

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Q15. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q16. I have provided the most recent chart note, labs, and additional clinical information to support the information provided on this request form.

☐ Yes ☐ No

Q17. Additional Comments

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.