

**XOLAIR® PREAUTHORIZATION
PHYSICIAN FAX FORM**

The following documentation is **REQUIRED** for preauthorization. Incomplete forms will be returned for additional information.

Patient Information

Today's Date: _____

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Patient Telephone Number:
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Insurance Information

BCBS ID Number:	Group Number:
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Physician/Clinic Information

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip Code:	Phone Number:		Secure Fax Number:	

Preauthorization Information

Requested Drug Name: _____	ICD-10 Diagnosis Code: _____
Requested Dose: _____ every _____ weeks. Length of treatment: _____	
Has this patient been previously treated with Xolair?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
For allergic asthma only:	
a. Has the patient had a positive skin test or RAST to a perennial aeroallergen?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Has the patient failed, is unresponsive to, or inadequately controlled on high-dose inhaled corticosteroids +/- long-acting beta agonist, leukotriene modifier, or theophylline?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide medical history and explain why each medication was discontinued: _____	
c. Please list baseline serum IgE level:	
Date Tested: _____ Patient Weight (kg): _____ Pre-treatment Serum IgE (IU/mL): _____	
d. Has the patient's weight changed requiring a dose adjustment?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. If this is a renewal, have the patient's asthma symptoms improved since the initiation of Xolair therapy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
I. Is the patient continuing inhaled corticosteroid therapy? If no, please explain. _____	
II. Has the patient's weight changed requiring a dose adjustment?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
For chronic idiopathic urticaria (CIU) only:	
a. Does the patient have a history of chronic idiopathic urticaria for at least six months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Does the patient have a documented failure, contraindication, or intolerance to a second generation non-sedating H1 antihistamine (e.g., Zyrtec®, Allegra®, Claritin®) at the maximum recommended dose?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list the drug/dose/duration: _____	
c. Please provide clinical information and documentation for the use of this medication. *If this is a renewal, please indicate whether this therapy has resulted in a reduction in symptoms*: _____	

Please fax or mail this form to:

Prime Therapeutics
Pharmacy Department - UM
1919 Aksarben Drive • PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877.232.6726

Phone: 877.999.2374

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