Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/pharmacy.html

Xolair
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
What medication(s) has member tried and failed for this diagnosis? Please specify:			
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:		☐ Yes	☐ No

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information		
☐ **Allergic Asthma**		
Has documentation (e.g., chart notes) been submitted confirming diagnosis of moderate to severe persistent allergic asthma?	☐ Yes	☐ No
Has documentation (e.g., chart notes, lab values) been submitted confirming a positive skin test or in vitro reactivity to a perennial aeroallergen?	☐ Yes	☐ No
Is the member 12 years of age or older with documentation of a pre-treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL?	☐ Yes	☐ No
Member is 6 years to less than 12 years of age with documentation of a pre-treatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL?	☐ Yes	☐ No

☐ Use of High-dose inhaled corticosteroid (ICS) (e.g., >500 mcg fluticasone propionate equivalent/day)	☐ Use of asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], LABA [e.g., salmeterol], tiotropium)	☐ Use of one maximally dosed COMBO ICS/LABA product (e.g., Advair [fluticasone propionate-salmeterol], Symbicort [budesonide-formoterol], Breo Ellipta [fluticasone-vilanterol])

☐ **Renewal Requests ONLY**

Was documentation (e.g., chart notes) submitted confirming a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in FEV1, decreased use of rescue medications)?	☐ Yes	☐ No
Are there paid claims or documentation (e.g., chart notes) submitted confirming patient continues to be treated with an ICS (e.g., fluticasone, budesonide) WITH OR WITHOUT additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], LABA [e.g., salmeterol], tiotropium)?	☐ Yes	☐ No
Is there is a contraindication or intolerance to these medications?	☐ Yes	☐ No

☐ **Chronic Spontaneous Urticaria**			
Was documentation (e.g., chart notes), confirming diagnosis of chronic spontaneous urticaria submitted?	☐ Yes	☐ No	
Does the member have persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a C/I or intolerance to H1 antihistamines?	☐ Yes	☐ No	
Does the member have paid claims or documentation has been submitted (e.g., chart notes) confirming concurrent use with an H1 antihistamine, unless there is a C/I or intolerance to H1 antihistamines?	☐ Yes	☐ No	
Member have TWO of the following, with paid claims or submission of documentation (e.g., chart notes) as confirmation:	☐ Doxepin	☐ H1-antihistamine	☐ H2-antihistamine (famotidine, cimetidine)
	☐ hydroxyzine	☐ Leukotriene modifier (montelukast)	
☐ **Renewal Requests ONLY**			
Has the member's disease status been RE-EVALUATED since the last authorization to confirm the patient's condition warrants continued treatment?	☐ Yes	☐ No	
Submission of documentation (e.g., chart notes) confirming patient has experienced at least ONE of the following:	☐ Reduction in itching severity from baseline	☐ Reduction in the number of hives from baseline	

☐ **Chronic Rhinosinusitis with Nasal Polyps**		
Submission of documentation (e.g., chart notes) confirming TWO or more of the following symptoms for ≥12 weeks:	☐ Mucopurulent discharge	☐ Nasal obstruction and congestion
	☐ Decreased or absent sense of smell	☐ Facial pressure or pain
Submission of documentation confirming ONE of the following:	☐ Evidence of inflammation on paranasal sinus exam or CT	☐ Nasal polyps
	☐ Evidence of purulence coming from paranasal sinuses OR ostiomeatal complex	
Submission of documentation confirming the following:	☐ Required prior sino-nasal surgery OR systemic corticosteroids in the previous 2 years	
Member has been unable to obtain symptom relief after ALL the following agents/classes of agents:	☐ Nasal saline irrigations	
	☐ Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone, etc.)	
	☐ Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)	

Is member currently on Xolair therapy?	☐ Yes	☐ No	Will member receive Xolair as ADD ON therapy in COMBO w/intranasal steroids?	☐ Yes	☐ No
			Is member receiving Xolair in COMBO with another biologic [e.g., Dupixent, Nucala]?	☐ Yes	☐ No

☐ **Renewal Requests ONLY**		
Was documentation (chart notes, lab values) submitted confirming a positive clinical response to Xolair therapy?	☐ Yes	☐ No
Will member receive Xolair as ADD ON therapy in COMBO w/intranasal steroids?	☐ Yes	☐ No
Is member receiving Xolair in COMBO with another biologic [e.g., Dupixent, Nucala]?	☐ Yes	☐ No

☐ **IgE Medicated Food Allergy**		
Documentation (chart notes, lab values) submitted, confirming diagnosis of IgE Mediated Food Allergy as evidenced by ONE of the following:	☐ Positive skin prick test (defined as greater than or equal to 4mm wheal greater than saline control) to food	
	☐ Positive food specific IgE (greater than or equal to 6kUA/L)	
	☐ Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300mg of food protein	
Does member have clinical history of IgE Mediated Food Allergy OR documentation (chart notes, lab values) was submitted confirming a HX of severe allergic response, including anaphylaxis, following exposure to one or more foods?	☐ Yes	☐ No

☐ Xolair is used in conjunction with food allergen avoidance	☐ Documentation was submitted confirming baseline (pre-Xolair treatment) serum total IgE level is ≥ 30 IU/mL AND ≤ 1850 IU/mL	☐ Documentation was submitted confirming dosing is according to serum total IgE levels AND body weight

☐ **Renewal Requests ONLY**		
Was documentation (chart notes, lab values) submitted confirming a positive response to therapy (e.g., reduction of type 1 allergic reactions, including anaphylaxis, following accidental exposure to one or more foods)?	☐ Yes	☐ No
Will Xolair be used in conjunction with food allergen avoidance?	☐ Yes	☐ No
Was documentation (chart notes, lab values) submitted confirming that dosing will continue to be based on body weight AND pretreatment total IgE serum levels?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.