



Fax completed prior authorization request form to 855-247-3677 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:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
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:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Directions for Use:	Strength:		Dosage Form:		
	Quantity:	Day	Duration of Therapy/Use:		
		Supply:			
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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					
<input type="checkbox"/> Allergic Asthma					
Has documentation (e.g., chart notes) been submitted confirming diagnosis of moderate to severe persistent allergic asthma?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has documentation (e.g., chart notes, lab values) been submitted confirming a positive skin test or in vitro reactivity to a perennial aeroallergen?				<input type="checkbox"/> Yes	<input type="checkbox"/> 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?				<input type="checkbox"/> Yes	<input type="checkbox"/> 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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Use of High-dose inhaled corticosteroid (ICS) (e.g., >500 mcg fluticasone propionate equivalent/day)	<input type="checkbox"/> Use of asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], LABA [e.g., salmeterol], tiotropium)		<input type="checkbox"/> Use of one maximally dosed COMBO ICS/LABA product (e.g., Advair [fluticasone propionate-salmeterol], Symbicort [budesonide-formoterol], Breo Ellipta [fluticasone-vilanterol])		
<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Is there is a contraindication or intolerance to these medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<input type="checkbox"/> Chronic Spontaneous Urticaria					
Was documentation (e.g., chart notes), confirming diagnosis of chronic spontaneous urticaria submitted?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Member have TWO of the following, with paid claims or submission of documentation (e.g., chart notes) as confirmation:	<input type="checkbox"/> Doxepin	<input type="checkbox"/> H1-antihistamine	<input type="checkbox"/> H2-antihistamine (famotidine, cimetidine)		
	<input type="checkbox"/> hydroxyzine	<input type="checkbox"/> Leukotriene modifier (montelukast)			
<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Submission of documentation (e.g., chart notes) confirming patient has experienced at least ONE of the following:	<input type="checkbox"/> Reduction in itching severity from baseline	<input type="checkbox"/> Reduction in the number of hives from baseline			
<input type="checkbox"/> Chronic Rhinosinusitis with Nasal Polyps					
Submission of documentation (e.g., chart notes) confirming TWO or more of the following symptoms for ≥12 weeks:	<input type="checkbox"/> Mucopurulent discharge	<input type="checkbox"/> Nasal obstruction and congestion			
	<input type="checkbox"/> Decreased or absent sense of smell	<input type="checkbox"/> Facial pressure or pain			
Submission of documentation confirming ONE of the following:	<input type="checkbox"/> Evidence of inflammation on paranasal sinus exam or CT	<input type="checkbox"/> Nasal polyps			
	<input type="checkbox"/> Evidence of purulence coming from paranasal sinuses OR ostiomeatal complex				
Submission of documentation confirming the following:	<input type="checkbox"/> 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:	<input type="checkbox"/> Nasal saline irrigations				
	<input type="checkbox"/> Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone, etc.)				
	<input type="checkbox"/> Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)				
Is member currently on Xolair therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will member receive Xolair as ADD ON therapy in COMBO w/intranasal steroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Is member receiving Xolair in COMBO with another biologic [e.g., Dupixent, Nucala]?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Requests ONLY					
Was documentation (chart notes, lab values) submitted confirming a positive clinical response to Xolair therapy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Will member receive Xolair as ADD ON therapy in COMBO w/intranasal steroids?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is member receiving Xolair in COMBO with another biologic [e.g., Dupixent, Nucala]?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> IgE Medicated Food Allergy					
Documentation (chart notes, lab values) submitted, confirming diagnosis of IgE Mediated Food Allergy as evidenced by ONE of the following:	<input type="checkbox"/> Positive skin prick test (defined as greater than or equal to 4mm wheal greater than saline control) to food				
	<input type="checkbox"/> Positive food specific IgE (greater than or equal to 6kUA/L)				
	<input type="checkbox"/> 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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Xolair is used in conjunction with food allergen avoidance	<input type="checkbox"/> Documentation was submitted confirming baseline (pre-Xolair treatment) serum total IgE level is ≥ 30 IU/mL AND ≤ 1850 IU/mL	<input type="checkbox"/> Documentation was submitted confirming dosing is according to serum total IgE levels AND body weight			

<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will Xolair be used in conjunction with food allergen avoidance?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 800-564-5465 to check the status of a request.