Prior Authorization Form

Xolair® (omalizumab)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ **Xolair®**
Quantity____________ Refill x____________months
Instructions____
Physician's signature_________________________ Provider NPI: ___________________ MD# _________________________
Date:______________________ Date medication needed______________________

Patient Information
Patient's name__________________________________
Patient's address____________________________
City, State, Zip: _______________________________________
Patient's phone # _________________________
Patient's ID#:___________________ DOB ____________

Prescriber Information
Prescribing physician_________________________
Office address_______________________________
City, State, Zip: _______________________________________
Office contact_______________________________
Office #______________________ Fax# ___________________

Upon approval, delivery is available. Complete section below.

☐ **No Delivery Requested**	☐ **Delivery Requested**	
☐ **Physician Supply, authorization only [Flex series]**	☐ **Physician's office**	☐ **Patient's home**
☐ **Member Pick up at pharmacy if benefit available**	**Preferred Vendor:** ______________________________________	

****A copy of the prescription must accompany the medication request****

1. **PHYSICIAN'S SPECIALTY (required, specify all)** ____

2. **DIAGNOSIS FOR DRUG REQUESTED**
☐ Moderate to severe asthma
☐ Other (specify)_____________________________

3. **PATIENT'S INFORMATION:**
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 inhaled corticosteroids? ☐ Yes ☐ No

4. **PATIENT HISTORY**
☐ New start ☐ Continued Treatment

Please list any previous or current therapies related to the diagnosis:

Drug name	**Dates**	**Duration**
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

Please add any other supporting medical information that may be useful in the decision-making process:
____
____
____

FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only
Document #_________________________
M F Rx coverage Y N
Previous Auth Y N
Approved **Reviewer Initials**_______________

Vendor___________________
LOB_________________
STANDARD - SELECT
Auth#_________________________
Date_______________Coverage effective date / /

Billing Code_____________ **M / Rx**
Processor Initials____________
Date______________________
From_______________ To_____________

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield.
Independent licensees of the Blue Cross and Blue Shield Association.