PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Xolair® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Allergic asthma
❑ Chronic idiopathic urticaria
❑ Other diagnosis:_____ICD-10 Code(s): _____

Provider's Specialty:

Select if Xolair is prescribed by or in consultation with one of the following specialists:
- ❑ Allergist/immunologist
- ❑ Dermatologist
- ❑ Pulmonologist

For allergic asthma, answer the following:

Does the patient have a diagnosis of moderate to severe persistent allergic asthma? ❑ **Yes** ❑ **No**

Does the patient have a pre-treatment serum immune globulin (IgE) level between 30 to 1300 IU/mL? ❑ **Yes** ❑ **No**

Does the patient have positive skin test or in vitro reactivity to a perennial aeroallergen? ❑ **Yes** ❑ **No**

Are symptoms adequately controlled on a high-dose inhaled corticosteroid and a long-acting beta2-agonist combination for at least 3 months? ❑ **Yes** ❑ **No**

Has the patient been adherent within a 12 month period and is currently adherent with asthma therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Select if the patient has experienced improvement with treatment as defined by one of the following:
- ❑ Reduction in number of asthma exacerbations from baseline (i.e., asthma exacerbation requiring treatment with systemic corticosteroids or doubling of inhaled corticosteroid [ISC] dose from baseline)
- ❑ Improvement in forced expiratory volume in 1 second (FEV1) from baseline
- ❑ Decreased use of rescue medications from baseline

For chronic idiopathic urticaria, answer the following:

Does the patient have persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or intolerance to the following additional therapies:
- ❑ Doxepin
- ❑ H1 antihistamine
- ❑ H2 antagonist
- ❑ Hydroxyzine
- ❑ Leukotriene receptor antagonist

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Reauthorization:

Has the patient's disease status been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment? ❑ **Yes** ❑ **No**

Has the patient experienced a reduction in itching severity or a reduction in the number of hives from baseline? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	