



P.O. Box 200354
 Pittsburgh, PA 15251-0354
 1-866-578-6337



XOLAIR REQUEST FAX FORM

Please fax completed form to our Pharmacy Services Department at
(505) 923-5540 or 1-800-724-6953

For help with this form, please call (505) 923-5757 or toll-free 1-888-923-5757 (option 3).

PATIENT INFORMATION

Patient Name (First):		Last:		Initial:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Patient Address:			City:	State:	ZIP:
Daytime Phone:	Evening Phone:	Cell Phone:	Primary Language:		

INSURANCE INFORMATION

Member ID Number:	Social Security Number:	DOB (mm/dd/yy):
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PRESCRIPTION INFORMATION

Drug: XOLAIR	Dose:	Quantity:
Sig:	Refill: _____ Months	Stop Date:
ICD-9 Code:	Diagnosis:	

MEDICAL ASSESSMENT

PLEASE PROVIDE ALL KNOWN INFORMATION

Criteria for approval of Xolair:

1. Requesting physician is an allergist or pulmonologist.
2. Member age is 12 or greater.
3. IgE level \geq 30 IU/ml.
4. Specific evidence of "allergic asthma", as supported by clinical and laboratory findings such as positive skin tests, symptom patterns, etc.
5. Failure on a minimum 6-month trial of inhaled steroid and long-acting beta-2 agonist combination therapy at maximum doses.
6. Evidence of persistent symptoms requiring frequent rescue therapy, practitioner visits despite inhaled corticosteroids, or ER visits.

Please fax all lab data, positive skin tests, chart notes and supporting evidence pertaining to the above criteria for approval that support your clinical justification for Xolair. Failure to provide this information will result in a denial of the request for an exception.

PRESCRIBER INFORMATION

Physician Name (please print):	Signature:	
Specialty:	NPI/DEA#	
Address (include all Suite, Building Numbers, etc.):		
Office Staff Contact Name:	Phone Number (include ext):	FAX Number :

SHIPPING INFORMATION

Date Needed: _____	Ship To: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member Home Address <input type="checkbox"/> Other _____	
PRESBYTERIAN PHARMACY SERVICES USE ONLY	<input type="checkbox"/> Medical <input type="checkbox"/> PBM	Prior Authorization Number: _____
<input type="checkbox"/> ASO <input type="checkbox"/> COMM <input type="checkbox"/> MCAID <input type="checkbox"/> PIC <input type="checkbox"/> SRCARE	Group _____	
<input type="checkbox"/> Approved	Comments:	Date:
<input type="checkbox"/> Denied	Comments:	Date:
Pharmacist Signature:	Medical Director Signature:	

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