

XOLAIR REQUEST FORM

Prior Authorization Request for WellCare of Florida

FAX to 1-866-825-2884 WellCare Pharmacy - Injectable Infusion Department

Complete each section legibly and completely (include any additional necessary medical records or laboratory results)

Member ID#				Date Submitted			
Name				Provider ID#			
Address				Name			
City	State	Zip		Address	State	Zip	
Phone	SS #			City	Fax		
Height	Wt	DOB		Phone	Alternate Fax		
Dx	ICD9			Alternate Phone	Contact		

Diagnosis Specialty: Pulmonologist Allergist

<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	ICD-9 493.____ (Complete 5 th digit to indicate status asthmaticus condition)	NIH Asthma Severity Classification
<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	ICD-9 _____	<input type="checkbox"/> Severe Persistent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Mild Intermittent

Current Concomitant Therapies <i>(Check all that apply)</i>	<input type="checkbox"/> Short Acting Beta Agonist	<input type="checkbox"/> Inhaled Corticosteroid	<input type="checkbox"/> Oral Steroids	<input type="checkbox"/> Combination therapy (LAB/ICS)
	Drug _____	Drug _____	Drug _____	Drug _____
	Duration _____	Duration _____	Duration _____	Duration _____
	<input type="checkbox"/> Long Acting Beta Agonist	<input type="checkbox"/> Leukotriene Modifier	<input type="checkbox"/> Immunotherapy	<input type="checkbox"/> Other (specify)
Drug _____	Drug _____	Drug _____	Drug _____	
Duration _____	Duration _____	Duration _____	Duration _____	

Is patient compliant with use of controller medications (moderate doses of inhaled corticosteroids plus a long acting beta-agonist or leukotriene inhibitor) during the past three months? Yes No

In the past 12 months, has the patient had ≥ 3 incidents where controller medication failed, resulting in treatment with oral/ or injected corticosteroids, emergency room/urgent center or clinical office visit, or hospital admission? Yes No

Lab Results <i>(Send copy of results)</i>	Test Date _____	Positive <input type="checkbox"/> Skin or <input type="checkbox"/> RAST test to a <u>perennial aeroallergen</u> <i>(check allergens tested)</i>
	IgE test results _____ IU/ml <i>(Patients with IgE levels > 700 or < 30 are not candidates for Xolair treatment)</i>	<input type="checkbox"/> Dust Mites <input type="checkbox"/> Dog or Cat <input type="checkbox"/> Cockroach
	Peak Flow: _____ % of predicted with _____ % variability	<input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
	FEV1 _____	FEV1/FVC _____

Prescription Type **New Start** **Continued Tx** **Drug Allergies** NKDA

Dosage	Xolair Dose Determination by Baseline Serum IgE Level and Body Weight (Package Revised July 2007)					NOTE: Doses above the shaded cells are given every 4 weeks; doses within the gray shading are administered every 2 weeks.	
		Pre-treatment Serum IgE (IU/ml)	Body Weight (kg)				
			30-60	> 60-70	> 70-90		>90-150
	Date	30-100	150	150	150		300
		>100-200	300	300	300		225
	Patient Weight (kg)	>200-300	300	225	225		300
		>300-400	225	225	300		NOT
		>400-500	300	300	375		FDA APPROVED
	>500-600	300	375	FDA APPROVED			
	>600-700	375	FDA APPROVED				

DOSE: _____ mg/dose subcutaneously every _____ weeks

Dispense 1 month(s) supply Refill _____ times

PHYSICIAN SIGNATURE