XOLAIR REQUEST FORM

Prior Authorization Request for WellCare of Georgia Medicaid

FAX to 1-866-455-6558 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**

☐ **Primary** ☐ **Secondary**

☐ **Primary** ☐ **Secondary**

ICD-9 493.____ ***(Complete 5th digit to indicate status asthmaticus condition)***

ICD-9 _____

NIH Asthma Severity Classification

- ☐ Severe Persistent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Mild Intermittent

Current Concomitant Therapies *(Check all that apply)*

☐ **Short Acting Beta Agonist**	☐ **Inhaled Corticosteroid**	☐ **Oral Steroids**	☐ **Combination therapy (LAB/ICS)**
Drug _____	Drug _____	Drug _____	Drug _____
Duration _____	Duration _____	Duration _____	Duration _____
☐ **Long Acting Beta Agonist**	☐ **Leukotriene Modifier**	☐ **Immunotherapy**	☐ **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 (***Send copy of results***)

Test Date _____

IgE test results _____**IU/ml**

(***Patients with IgE levels > 700 or <30 are not candidates for Xolair treatment***)

Positive ☐ **Skin or** ☐ **RAST test to a perennial aeroallergen**

(check allergens tested)

☐ Dust Mites ☐ Dog or Cat ☐ Cockroach

☐ Other _____ ☐ Other _____

Peak Flow: _____% of predicted with _____% variability **FEV1** _____ **FEV1/FVC** _____

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

Dosage

Date

_____

Patient Weight _____ **(kg)**

Xolair Dose Determination by Baseline Serum IgE Level and Body Weight (Package Revised July 2007)

Pre-treatment Serum IgE (IU/ml)	Body Weight (kg)			
	30-60	> 60-70	> 70-90	>90-150
30-100	150	150	150	300
>100-200	300	300	300	225
>200-300	300	225	225	300
>300-400	225	225	300	NOT
>400-500	300	300	375	
>500-600	300	375	FDA	
>600-700	375	APPROVED		

NOTE: Doses above the shaded cells are given every 4 weeks; doses within the gray shading are administered every 2 weeks.

___ **DOSE:** _____ mg/dose subcutaneously **every** _____ **weeks**

Dispense ☐1 month(s) supply **Refill** _____ **times**

PHYSICIAN SIGNATURE

Rev: 02/09

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