



WellCare®

XOLAIR REQUEST FORM

Coverage Determination Request for **WellCare of New York**
 FAX to **1-866-388-1517** 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

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

Specialty: Pulmonologist Allergist

NIH Asthma Severity Classification
 Severe Persistent
 Mild Persistent
 Moderate Persistent
 Mild Intermittent

Current Concomitant Therapies (Check all that apply)

<input type="checkbox"/> Short Acting Beta Agonist Drug _____ Duration _____	<input type="checkbox"/> Inhaled Corticosteroid Drug _____ Duration _____	<input type="checkbox"/> Oral Steroids Drug _____ Duration _____	<input type="checkbox"/> Combination therapy (LAB/ICS) Drug _____ Duration _____
<input type="checkbox"/> Long Acting Beta Agonist Drug _____ Duration _____	<input type="checkbox"/> Leukotriene Modifier Drug _____ Duration _____	<input type="checkbox"/> Immunotherapy Drug _____ Duration _____	<input type="checkbox"/> Other (specify) Drug _____ 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

Date	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
	30-100	150	150	150
	>100-200	300	300	300
	>200-300	300	225	225
	>300-400	225	225	300
	>400-500	300	300	375
	>500-600	300	375	375
	>600-700	375	375	375

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