



NC DHB Pharmacy Request for Prior Approval Monoclonal Antibody Therapy – Xolair

Recipient Information

1. Recipient Last Name: _____ 2. First Name: _____
3. Recipient ID # _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: [] Health Choice: []

Prescriber Information

7. Prescribing Provider #: _____ NPI: [] or Atypical: []
8. Prescriber DEA #: _____
Requester Contact Information: Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: Xolair 10. Strength: _____ 11. Quantity Requested: _____
12. Length of Therapy (in days): [] up to 30 [] 60 [] 90 [] 120 [] 180 [] 365 [] Other: _____

Clinical Information

Allergic Asthma: New Therapy

- 1. Is the patient 6 years of age or older? [] Yes [] No
2. Does the patient have a diagnosis of Asthma? [] Yes [] No
3. Has the patient used inhaled corticosteroids in the past 45 days and have excessive use of short-acting beta-agonists in the past 60 days? [] Yes [] No
4. Has the patient used inhaled corticosteroids in the past 45 days and have short-term oral steroid use in the past 45 days? [] Yes [] No
5. Has the patient used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days? [] Yes [] No
6. Has the patient had a percutaneous skin test or RAST allergy test in the past 12 months indicating reactivity to at least one perennial aeroallergen? [] Yes [] No
7. Does the patient have an IgE level above 30IU/ml? [] Yes [] No
Please list level: _____

Allergic Asthma: Continuation of Therapy

- 8. While on Xolair, has the patient had continued clinical benefit and reductions in asthma exacerbations from baseline? [] Yes [] No
9. What is the patient's current asthma status? _____
10. What has been the patient's response to Xolair treatment? _____
11. What is the patient's current smoking status: _____



Chronic Idiopathic Urticaria

12. Is the patient 12 years of age or older? Yes No
13. Does the patient have a diagnosis of moderate to severe chronic idiopathic urticaria? Yes No
14. Does the patient continue to remain symptomatic despite treatment with at least two (2) H1 antihistamines and one leukotriene modifier? Yes No
15. Is Xolair being prescribed by or in consultation with an allergy specialist? Yes No

Other: _____

16. Please list the diagnosis with explanation:

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318