mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Xolair
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to requests howing medical justification are required to support diagnosis

Member Information							
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female		Height:			
Member ID:	City:	State:		Weight:			
Prescribing Provider Information							
Provider Name (first & last):	Specialty:	NPI#	DEA#				
Office Address:	City:	State:	Zip Code:				
Office Contact:	Office Phone	Office Fax:					
Dispensing Pharmacy Information							
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:					
Requested Medication Information							
What medication(s) has member tried and failed for this diagnosis? Please specify:							
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	Diagnosis:	ICD-10 Code:					
Are there any contraindications to formulary medications? If yes, please specify:				☐ Yes	☐ No		
Directions for Use:	Strength:	Dosage Form:					
	Quantity:	Day Supply:	Duration of Therapy/Use:				
Turn-Around Time for Review							
☐ Standard – (24 hours)	☐ **Urgent** – w aiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____						
Clinical Information							
☐ **Moderate to Severe Persistent Asthma**							
Does member have a positive skin test OR in-vitro reactivity to perennial allergen (dust mite, animal dander, cockroach, etc.)?	☐ Yes	☐ No	Is immunoglobulin E (IgE) betw een 30 and 1300 IU/mL?	☐ Yes	☐ No		
Has member been compliant w ith medium to high dose ICS + LABA for 3 months OR other controller medications (LTRA or theophylline), if intolerant to LABA?				☐ Yes	☐ No		
Asthma symptoms are poorly controlled on 1 of above regimens as defined by ANY of the follow ing:	☐ Daily use of rescue medications	☐ Nighttime symptoms occurring more than once per w eek	☐ At least 2 exacerbations in last 12 months requiring additional medical treatment (systemic corticosteroids, ER visits or hospitalization)				
Will member be receiving Nucala, Fasenra, Cinqair OR Dupixent?				☐ Yes	☐ No		
☐ Renew al Requests ONLY							
Has member demonstrated clinical improvement?	☐ Yes	☐ No	Was there decreased use of rescue medications or systemic corticosteroids?	☐ Yes	☐ No		
Was there a reduction in number of ER visits or hospitalizations?	☐ Yes	☐ No	Was member compliant w ith asthma controller medications?	☐ Yes	☐ No		
☐ **Chronic Urticaria**							
Is member currently receiving H1 antihistamine therapy?	☐ Yes	☐ No	Was there failure of a 4-w eek trial w ith high dose cetirizine, loratadine or fexofenadine?	☐ Yes	☐ No		
There w as failure of a 4-week trial of at least THREE of the follow ing combinations:	☐ H1 antihistamine + Leukotriene inhibitor (montelukast or zafirlukast)						
	☐ H1 antihistamine + H2 antihistamine (ranitidine or cimetidine)						
	☐ H1 antihistamine + Doxepin						
	☐ 1st generation + 2nd generation antihistamine						
☐ Renew al Requests ONLY							

Has member demonstrated adequate symptom control such as decreased itching?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.