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/chp-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 request showing 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** – waiting 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 Asthma**		
Classification of asthma as uncontrolled OR inadequately controlled as defined by ONE of the following:	☐ Poor symptom control (ACQ score >1.5 or ACT score <20)	☐ 2 or more bursts of systemic steroids for at least 3 days each in previous 12 months
	☐ Asthma-related emergency TX (ER visit, hospital admit OR unscheduled DR's office visit for nebulizer OR other urgent TX)	
	☐ Airflow limitation (after appropriate bronchodilator withhold FEV1 <80% predicted defined as less than lower limit of normal)	
	☐ Member is currently dependent on oral steroids for TX of asthma	
☐ Baseline (pre-omalizumab TX) serum total IgE level ≥ 30 IU/mL AND ≤ 1500 IU/mL	☐ Member is currently dependent on oral steroids for TX of asthma	☐ Positive skin test OR in vitro reactivity to a perennial aeroallergen
☐ Use of ONE MAX-dosed COMBO ICS-LABA [fluticasone propionate-salmeterol (AirDuo, Advair), budesonide-formoterol (Symbicort)]	☐ Use of ONE high-dose ICS [ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]	☐ Use of one ADD'L asthma controller (LABA - olodaterol (Striverdi) OR indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]
Is the member receiving Xolair with Nucala, Fasenra, Cinqair OR Dupixent?	☐ Yes	☐ No
☐ **Renewal Requests ONLY**		

Documentation of positive clinical response as demonstrated by ONE of the following:	☐ Reduction in frequency of exacerbations	☐ Decreased utilization of rescue medications
	☐ Reduction in severity OR frequency of asthma-related symptoms (wheezing, SOB, coughing)	☐ Increase in % predicted FEV1 from pre-TX baseline

☐ Xolair is used in COMBO with an ICS-containing controller medication	Is the member receiving Xolair with Nucala, Fasenra, Cinqair OR Dupixent?	☐ Yes	☐ No

☐ **Chronic Idiopathic Urticaria**	
☐ Member remains symptomatic despite at least a 2-week trial of OR HX of C/I or intolerance with TWO H1-antihistamines [Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]	
☐ Member remains symptomatic despite at least a 2-week trial of OR HX of C/I or intolerance to the following taken in combination: 2nd generation H1-antihistamine [Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]	
Member has ONE of the following:	☐ A different 2nd generation H1-antihistamine [Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]
	☐ H2-antihistamine [Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]
	☐ 1st generation H1-antihistamine [Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]
	☐ Leukotriene modifier [Singulair (montelukast)]

☐ **Renewal Requests ONLY**		
Is there documentation of positive clinical response to therapy (reduction in exacerbations, itch severity, hives)?	☐ 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 833-711-0776to check the status of a request.