



**Outpatient Medical Injectable
XOLAIR Request Form
Fax to 833-581-1861
(Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ Medicare Commercial*

Ordering/Attending Provider Name: _____ NPI: _____

Ordering/Attending Provider Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Servicing Facility/Vendor Name: _____ Facility NPI: _____

Servicing Facility/Vendor Address: _____

HCPCS J Code: _____ Requested Start Date of Service: _____

ICD10 Diagnosis Code(s): _____

Buy & Bill Drug Supplied by Specialty Pharmacy (Pharmacy Name: _____ NPI: _____)

For providers in Western PA and West Virginia, the specialty pharmacy will be assigned by Free Market Health

For Asthma:
Does the member have MODERATE TO SEVERE persistent Asthma ? <input type="checkbox"/> YES <input type="checkbox"/> NO
Has the member had a positive skin test or in vitro reactivity to a perennial aeroallergen? <input type="checkbox"/> YES <input type="checkbox"/> NO
Please list any medications (inhalers, oral medications, injections) the member has been on over the past year for asthma:
<ul style="list-style-type: none"> • Name: _____ Dose: _____ Start Date: _____ Stop Date: _____ • Name: _____ Dose: _____ Start Date: _____ Stop Date: _____ • Name: _____ Dose: _____ Start Date: _____ Stop Date: _____ • Name: _____ Dose: _____ Start Date: _____ Stop Date: _____
Are the members asthma symptoms inadequately controlled? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is the member compliant with their current therapeutic regimen? <input type="checkbox"/> YES <input type="checkbox"/> NO

****Please verify member's eligibility and benefits through the health plan****

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For Asthma:

Does the member have a baseline IgE titer greater than or equal to 30IU/mL? YES NO

If YES, please provide:

- IgE _____ IU/microliter Date of lab draw: _____

<input type="checkbox"/> New Start	<input type="checkbox"/> Continuation of Therapy
The use of Xolair has resulted in clinical improvement documented by: <i>(Check all that apply)</i>	
<input type="checkbox"/> Decreased utilization of rescue medications	
<input type="checkbox"/> Decreased frequency of exacerbations	
<input type="checkbox"/> Reduction in reported asthma-related symptoms	
Will Xolair be prescribed <u>in combination with</u> Fasenra, Nucala, Cinqair or Dupixent? <input type="checkbox"/> YES <input type="checkbox"/> NO	

For Urticaria:

Does the member have **CHRONIC Spontaneous Urticaria (CSU)**? YES NO

Please list all medications the member has been on over the past year for urticaria

- Name: _____ Dose: _____ Start Date: _____ Stop Date: _____
- Name: _____ Dose: _____ Start Date: _____ Stop Date: _____
- Name: _____ Dose: _____ Start Date: _____ Stop Date: _____
- Name: _____ Dose: _____ Start Date: _____ Stop Date: _____

<input type="checkbox"/> New Start	<input type="checkbox"/> Continuation of Therapy
Has treatment with Xolair resulted in a clinically meaningful response from baseline? <input type="checkbox"/> YES <input type="checkbox"/> NO	

For Nasal Polyps:

Does the member have **CHRONIC Rhinosinusitis with Nasal Polyps (CRSwNP)**? YES NO

Will Xolair be used as add-on maintenance therapy? YES NO

Has the member had an inadequate response to nasal corticosteroids? YES NO

<input type="checkbox"/> New Start	<input type="checkbox"/> Continuation of Therapy
Has treatment with Xolair resulted in a clinically meaningful response from baseline? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Please attach all pertinent clinical information

Attached: YES NO