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**? ☐ YES ☐ NO
Has the member had a positive skin test or in vitro reactivity to a perennial aeroallergen? ☐ YES ☐ NO
Please list any medications (inhalers, oral medications, injections) the member has been on over the past year for asthma: • 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? ☐ YES ☐ NO
Is the member compliant with their current therapeutic regimen? ☐ YES ☐ NO

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

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: _____

☐ **New Start**	☐ **Continuation of Therapy** **The use of Xolair has resulted in clinical improvement documented by:** *(Check all that apply)* ☐ Decreased utilization of rescue medications ☐ Decreased frequency of exacerbations ☐ Reduction in reported asthma-related symptoms **Will Xolair be prescribed *in combination with* Fasenra, Nucala, Cinqair or Dupixent?** ☐ YES ☐ 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: _____

☐ **New Start**	☐ **Continuation of Therapy** **Has treatment with Xolair resulted in a clinically meaningful response from baseline?** ☐ YES ☐ 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

☐ **New Start**	☐ **Continuation of Therapy** **Has treatment with Xolair resulted in a clinically meaningful response from baseline?** ☐ YES ☐ NO

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**