



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: _____

Drug Name and HCPCS Code: **XOLAIR (J2357)** Requested Start Date of Service: _____

ICD10 Diagnosis Code(s): _____

Dose: _____ Frequency: _____ Number of visits requested: _____ Date of Service: _____

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

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

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: _____

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

For Asthma:☐ 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

For IgE Mediated Food Allergy (complete below for NEW start and CONTINUATION of therapy):

Does the member have a **documented IgE mediated food allergy** that is confirmed by one of the following:

- Positive skin prick test (SPT)? ☐ YES ☐ NO
- Food allergen specific IgE antibodies? ☐ YES ☐ NO

Does the member experience type one (1) allergic reactions including anaphylaxis with exposure to allergen?

☐ YES ☐ NO

Does the member experience severe anaphylaxis when exposed to the allergen? ☐ YES ☐ NO

Will Omalizumab (Xolair) be used in conjunction with food allergen avoidance? ☐ YES ☐ NO

Does the provider attest that Omalizumab (Xolair) will not be used for emergency treatment of allergic reactions?

☐ YES ☐ NO

Please attach all pertinent clinical information

Attached:

☐

YES

☐

NO

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