



**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 ? <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
Does the member have a baseline IgE titer greater than or equal to 30IU/mL? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please provide: <ul style="list-style-type: none"> • 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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