HIGHMARK | HIGHMARK

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 *<u>in combination with</u>* 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**