

Physician XOLAIR® Prior Authorization Request Form

Fax to Keystone Mercy Pharmacy Services at 215-937-5018, or to speak to a representative call 800-588-6767. Form must be completed for processing.

Patient's Name: _____

Keystone Mercy ID#: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Phone #: _____

Birth date: _____

Physician's Name: _____

NPI #: _____

Physician Signature _____

Apt # or Suite #: _____

Address: _____

Zip Code: _____

City: _____ State: _____

Contact Person: _____ Phone #: _____

Fax #: _____

To be Administered from: _____ to _____

Drug Name: _____

Sig and Dose: _____

Current Weight: _____ lbs _____ kg

Naïve Therapy

Continuation of Therapy

1. Diagnosis: _____ ICD-9 Diagnosis Code: _____

- 2. Pulmonary Function Testing
 - Most recent FEV₁ % of Predicted _____ Date: _____ OR
 - Most recent FEV₁/FVC _____ % Date _____

3. Severity of Asthma mild moderate severe

- Frequency of daytime and nighttime symptoms _____

- Additional comments regarding the severity of the patient's asthma _____

<p>Labs (Please submit a copy of lab result and/or complete the following):</p> <p>Pre Xolair® Total Serum IgE: _____ IU/mL</p> <p>Date of labs: _____</p>

4. Is the patient receiving any medications (e.g. Beta-blockers, NSAIDS) that could potentially be contraindicated in asthma? _____

5. Please indicate which routine control medications the member is currently receiving including drug name, strength, dose and start date as well as if the patient was compliant: _____

6. Has the patient recently been hospitalized or visited the ER due to a severe asthma exacerbation while being compliant with high dose inhaled corticosteroids and long acting β₂ agonists? Yes No

7. If yes, please indicate dates of hospital admission and/or ER visit. Please attach additional information if necessary. _____

8. Please indicate the allergen(s) to which the patient has had a positive skin test (e.g. *dermatophagoides farinae*, *dermatophagoides pteronyssinus*, dog, cat, or cockroach) that are triggers for their asthma exacerbation(s) _____

9. Did the patient receive a full course of immunotherapy? Yes No Please comment: _____

10. What environmental measures have been attempted to avoid asthma allergen triggers and/or a reason for not making attempts to avoid allergen exposure: _____

PLEASE FILL OUT THIS SECTION FOR CONTINUATION OF THERAPY ONLY: (Attach additional information if necessary)

1. Please document clinical improvements in the patient's condition while taking Xolair® (e.g. symptoms, QOL) _____