Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Xolair - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient been previously approved for Xolair?

☐ Yes - Go to 2 ☐ No - Go to 3

Q2. For Renewal: Has the prescriber provided confirmation of a positive clinical response?

☐ Yes ☐ No

Q3. Is the prescriber a pulmonologist, allergist, immunologist, dermatologist or otolaryngologist?

☐ Yes ☐ No

Q4. Is the patient at least 1 year of age?

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of moderate to severe persistent asthma? If NO, go to 15.

☐ Yes ☐ No

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Q6. Does the patient have documentation of either of the following: A) Patient has tried (for at least 3 months) and failed oral corticosteroids and/or combination therapies (inhaled steroids, long acting beta-agonists, anti-leukotrienes, theophylline); OR
B) Patient is intolerant to oral corticosteroids and/or combination therapies (inhaled steroids, long acting beta-agonists, anti-leukotrienes, theophylline)?

☐ Yes ☐ No

Q7. Does the patient have daily asthma symptoms such as coughing, wheezing and dyspnea?

☐ Yes ☐ No

Q8. Does the patient have daily use of rescue inhaler such as a short acting beta2-agonist?

☐ Yes ☐ No

Q9. Does the patient have asthma attacks/exacerbations two or more times per week?

☐ Yes ☐ No

Q10. Does the patient have multiple visits to the emergency room in the previous 12 months?

☐ Yes ☐ No

Q11. Does the patient have one or more nights of nocturnal asthma causing awakening?

☐ Yes ☐ No

Q12. Does the patient have forced expiratory volume (FEV1) greater than 40 percent and less than 80 percent of predicted normal pre-inhaled steroids?
Labs must be attached.

☐ Yes ☐ No

Q13. Is there documentation of positive skin test, radioallergosorbent test (RAST), or in vitro reactivity to at least one perennial aeroallergen?
Labs must be attached.

☐ Yes ☐ No

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Q14. Is there clinical documentation showing of one of the following: A) immunoglobulin E (IgE) levels between 30 and 700 IU/mL for patients 12 years of age and older, or B) IgE levels between 30 and 1300 IU/mL for patients between the ages of 6 to less than 12 years? Labs must be attached.

☐ Yes ☐ No

Q15. Does the patient have a diagnosis of chronic spontaneous urticaria (CSU)? If NO, go to 17.

☐ Yes ☐ No

Q16. Does the patient meet either of the following: A) Patient remains symptomatic despite H1 antihistamine treatment; OR B) Patient has an intolerance or contraindication to H1 antihistamine treatment?

☐ Yes ☐ No

Q17. Does the patient have a diagnosis of nasal polyps? If NO, go to 20.

☐ Yes ☐ No

Q18. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to intranasal corticosteroids and trial of, intolerance to, or contraindication to systemic corticosteroid therapy?

☐ Yes ☐ No

Q19. Is there documentation showing that the patient will be treated with Xolair in combination with intranasal corticosteroids (if applicable)?

☐ Yes ☐ No

Q20. Does the patient have a diagnosis of IgE mediated food allergy?

☐ Yes ☐ No

Q21. Is there clinical documentation showing immunoglobulin E (IgE) levels between 30 and 1850 IU/ml?

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Member Name:	**Prescriber Name:**

☐ Yes	☐ No
Q22. Requested Duration: ☐ 12 months	☐ Other
Q23. Additional Information:	

Prescriber Signature _____ Date _____

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