



**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: \_\_\_\_\_

HCPCS J Code: \_\_\_\_\_ Requested Start Date of Service: \_\_\_\_\_

ICD10 Diagnosis Code(s): \_\_\_\_\_

Buy & Bill  Drug Supplied by Specialty Pharmacy (Pharmacy Name: \_\_\_\_\_ NPI: \_\_\_\_\_)

**For providers in Western PA and West Virginia, the specialty pharmacy will be assigned by Free Market Health**

<b>For Asthma:</b>	
Does the member have <b>MODERATE TO SEVERE persistent Asthma</b> ? <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:	
• 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	

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

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**For Asthma:**

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: \_\_\_\_\_

<input type="checkbox"/> <b>New Start</b>	<input type="checkbox"/> <b>Continuation of Therapy</b>
<b>The use of Xolair has resulted in clinical improvement documented by:</b> <i>(Check all that apply)</i>	
<input type="checkbox"/> Decreased utilization of rescue medications	
<input type="checkbox"/> Decreased frequency of exacerbations	
<input type="checkbox"/> Reduction in reported asthma-related symptoms	
<b>Will Xolair be prescribed <u>in combination with</u> Fasenra, Nucala, Cinqair or Dupixent?</b> <input type="checkbox"/> YES <input type="checkbox"/> 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: \_\_\_\_\_

<input type="checkbox"/> <b>New Start</b>	<input type="checkbox"/> <b>Continuation of Therapy</b>
<b>Has treatment with Xolair resulted in a clinically meaningful response from baseline?</b> <input type="checkbox"/> YES <input type="checkbox"/> 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

<input type="checkbox"/> <b>New Start</b>	<input type="checkbox"/> <b>Continuation of Therapy</b>
<b>Has treatment with Xolair resulted in a clinically meaningful response from baseline?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	

**Please attach all pertinent clinical information**

Attached:  YES  NO