**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**

| **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:<br>• Name:_____ Dose: _____ Start Date:_____ Stop Date: _____<br>• Name:_____ Dose: _____ Start Date:_____ Stop Date: _____<br>• Name:_____ Dose: _____ Start Date:_____ Stop Date: _____<br>• 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 |

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

**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: _____

| ☐ **New Start** | ☐ **Continuation of Therapy**<br><br>**The use of Xolair has resulted in clinical improvement documented by:**<br>*(Check all that apply)*<br><br>☐ Decreased utilization of rescue medications<br>☐ Decreased frequency of exacerbations<br>☐ Reduction in reported asthma-related symptoms<br><br>**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**<br><br>**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**<br>**Has treatment with Xolair resulted in a clinically meaningful response from baseline?** ☐ YES ☐ NO |
|---|---|

**Please attach all pertinent clinical information**

**Attached:** ☐ **YES** ☐ **NO**