



2024 MEDICARE 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.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, State Lic ID, and Specialty/facility name.

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.

Form with fields for Drug Name, Strength, and 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. 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 16.

Yes

No



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
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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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<b>Patient Name:</b>	<b>Prescriber Name:</b>
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 6 and 12 years of age? Labs must be attached.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Does the patient have a diagnosis of chronic idiopathic urticaria (CIU)? If No, go to 19.	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Does the patient have a diagnosis of nasal polyps?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Is there documentation showing that the patient will be treated with Xolair in combination with intranasal corticosteroids (if applicable)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Does the patient have a diagnosis of IgE mediated food allergy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. Is there clinical documentation showing immunoglobulin E (IgE) levels between 30 and 1850 IU/ml?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Q22. Additional Information:

Q23. Requested Duration:

12 months

Other

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2024 Medicare Prior Authorization Request