



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Xolair

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.**

<b>Member Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**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? If YES, go to 2. If NO, go to 3.

Yes  No

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. Does the patient have a diagnosis of moderate to severe persistent asthma? If YES, go to 5. If NO, go to 14.

Yes  No

Q5. Is there documentation showing that the patient had inadequate response, intolerance, or contraindication to both of the following medications: 1) Medium-to-high-dose inhaled corticosteroid, AND 2) Additional controller (i.e., LABA, LAMA, leukotriene modifier, or theophylline)?



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<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Does the patient have daily asthma symptoms such as coughing, wheezing and dyspnea? If YES, go to 11. If NO, go to 7.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Does the patient have daily use of rescue inhaler such as a short acting beta2-agonist? If YES, go to 11. If NO, go to 8.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does the patient have asthma attacks/exacerbations two or more times per week? If YES, go to 11. If NO, go to 9.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Does the patient have multiple visits to the emergency room in the previous 12 months? If YES, go to 11. If NO, go to 10.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Does the patient have one or more nights of nocturnal asthma causing awakening?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is there documentation of positive skin test, radioallergosorbent test (RAST), or in vitro reactivity to at least one perennial aeroallergen? Labs must be attached	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. 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.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	



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<p>Q13. Does the patient have a diagnosis of chronic spontaneous urticaria (CSU )? If YES, go to 14. If NO, go to 15.</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	
<p>Q14. Does the patient meet either of the following: A) patient remains symptomatic despite H1 antihistamine treatment, B) patient has an intolerance or contraindication to H1 antihistamine treatment?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	
<p>Q15. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP)? If YES, go to 16, If NO, go to 18.</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	
<p>Q16. Is there documentation showing that the patient had inadequate response, intolerance, or contraindication to intranasal corticosteroids and inadequate response, intolerance, or contraindication to systemic corticosteroid therapy?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	
<p>Q17. Is there documentation showing that the patient will be treated with Xolair in combination with intranasal corticosteroids (if applicable)? <a href="https://setup.pahub.com/Images/save.gif">https://setup.pahub.com/Images/save.gif</a></p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	
<p>Q18. Does the patient have a diagnosis of IgE mediated food allergy?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	
<p>Q19. Is there clinical documentation showing immunoglobulin E (IgE) levels between 30 and 1850 IU/ml?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	
<p>Q20. Requested Duration:</p> <p><input type="checkbox"/> 12 Months      <input type="checkbox"/> Other:</p>	



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**Member Name:**

**Prescriber Name:**

**Q21. Additional Information:**

Prescriber Signature

Date

v2026