

Xolair® (omalizumab) PreDetermination of Medical Benefits
Complete form in its entirety and fax to UM Call Center at (404) 848-2449

Click on grey boxes to type

Request Date: _____ / _____ / _____

Initial Authorization Request Re-Authorization Request; List Prior Auth Ref #: _____

Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419) Yes No

1. PATIENT INFORMATION			
Patient Last Name	Patient First Name	Patient ID Number	Patient DOB / /
Address		City	State / Zip Code /
Contact Phone Number () -			
Date of Diagnosis / /	Primary Diagnosis	ICD-9 Code(s)	Patient's Current Weight

2. PHYSICIAN INFORMATION			
Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address		City	State Zip Code
Office Phone Number () -	Office Fax Number () -	Office Contact Name	Physician Specialty

3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.			
Drug Name Xolair	HCPCS or CPT Code(s) J2357	Strength / Dose	
Direction for Use (SIG)			
Date patient is scheduled to be treated (need by date) / /	Service From Date / /	Service Thru Date / /	Number of Refills
Place of Service <input type="checkbox"/> MD Office <input type="checkbox"/> Pt's Home <input type="checkbox"/> Other: (please specify)			
Prescriber Signature			Date / /

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4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended.
If indicated, please provide **ALL** supporting lab results, progress notes, etc.

(1) Moderate to Severe Persistent Asthma

- Yes No Is pt ≥ 12 years old and have moderate or severe persistent asthma?
- Yes No Does pt have daily symptoms?
- Yes No Is pt using daily inhaled short-acting beta2-agonist(s)?
- Yes No Does pt have ≥ 2 exacerbations per week that may last for days?
- Yes No Does pt have nocturnal symptoms/awakenings > 1 time per week?
- Yes No Does pt have frequent nocturnal symptoms/awakenings, often 7x per week?
- Yes No Is pt's FEV₁ > 60% and < 80% predicted?
- Yes No Is pt's FEV₁ ≤ 60% predicted?
- Yes No Is pt's peak expiratory flow (PEF) variability > 30%?
- Yes No Are symptoms inadequately controlled with **combination controller** therapy (medium to high doses of inhaled corticosteroids **plus** a long-acting beta2-agonist or leukotriene modifier)?

Please provide controller therapy(ies): _____

Date last taken: _____

_____	/	/	_____
_____	/	/	_____
_____	/	/	_____

- Yes No Did pt have a positive skin test or in vitro reactivity to a perennial aeroallergen?
- Yes No Does pt have a serum IgE level ≥ 30 IU/mL?

Please provide current IgE level: _____

Date: _____

(2) Other Use(s) (This will not be reviewed unless all supporting evidence/documentation, labs, etc., are attached.)

5. PHYSICIAN SIGNATURE

	/ /
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Prescriber Signature

Date

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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Medical Policy Reference can be found at: www.bcbsga.com

Anthem UM Services, Inc. an independent company and is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.