



NC DMA Pharmacy Request for Prior Approval - Xolair

Recipient Information

*****DMA-3111 †

1. Recipient Last Name: _____ 2. First Name: _____
3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: **Xolair** 10. Strength: _____ 11. Quantity Requested: _____

12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

New Therapy

1. Is the patient 6 years of age or older? Yes No
2. Does the patient have a diagnosis of Asthma? Yes No
3. Has the patient used inhaled corticosteroids in the past 45 days and have excessive use of short-acting beta-agonists in the past 60 days? Yes No
4. Has the patient used inhaled corticosteroids in the past 45 days and have short-term oral steroid use in the past 45 days? Yes No
5. Has the patient used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days? Yes No
6. Has the patient had a percutaneous skin test or RAST allergy test in the past 12 months indicating reactivity to at least one perennial aeroallergen? Yes No
7. Does the patient have an IgE level above 30IU/ml? Yes No

Please list level: _____

Continuation of Therapy

8. While on Xolair, has the patient had continued clinical benefit and reductions in asthma exacerbations from baseline? Yes No
9. What is the patient's current asthma status? _____
10. What has been the patient's response to Xolair treatment? _____
11. What is the patient's current smoking status: _____

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

Fax this form to CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505