AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Monoclonal Antibodies: Xolair

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Requested: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Allergic Asthma: New Therapy

1. Is the beneficiary 6 years of age or older? Yes___ No___
2. Does the beneficiary weigh between 20kg (44lbs) and 150kg (330lbs)? Yes___ No___ Beneficiary's Weight: _____
3. Does the beneficiary have a diagnosis of Asthma? Yes___ No___
4. 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___
5. Has the beneficiary used inhaled corticosteroids in the past 45 days and have short-term oral steroid use in the past 45 days? Yes___ No___
6. Has the beneficiary used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days? Yes___ No___
7. Has the beneficiary had a percutaneous skin test or RAST allergy test in the past 12 months indicating reactivity to at least one perennial aeroallergen? Yes___ No___
8. Does the beneficiary have an IgE level above 30IU/ml? Yes___ No___ Please list level: _____

Allergic Asthma: Continuation of Therapy

9. While on Xolair, has the beneficiary had continued clinical benefit and reductions in asthma exacerbations from baseline? Yes___ No___
10. What is the beneficiary's current asthma status? _____
11. What has been the beneficiary's response to Xolair treatment? _____
12. What is the beneficiary's current smoking status? _____

Chronic Idiopathic Urticaria: New Therapy

13. Is the beneficiary 12 years of age or older? Yes___ No___
14. Does the beneficiary have a diagnosis of moderate to severe chronic idiopathic urticarial? Yes___ No___
15. Does the beneficiary continue to remain symptomatic despite treatment with at least two (2) H1 antihistamines AND one leukotriene modifier? Yes___ No___
16. Is Xolair being prescribed by or in consultation with an allergy specialist? Yes___ No___

Chronic Idiopathic Urticaria: Continuation of Therapy (please answer questions 13-17)

17. Is the beneficiary receiving continued clinical benefit from baseline supported by medical records? Yes___ No___
If Yes, please attach medical records.

Nasal Polyps: New Therapy

18. Is the beneficiary 18 years of age or older? Yes___ No___
19. Does the beneficiary weigh between 30kg (66lbs) and 150kg (330lbs)? Yes___ No___ Beneficiary's Weight: _____
20. Does the beneficiary have an IgE level above 30IU/ml? Yes___ No___ Please list level: _____
21. Does the beneficiary have a diagnosis of Nasal Polyps? Yes___ No___
22. Has the beneficiary tried and failed monotherapy with nasal steroids? Yes___ No___
23. Will the beneficiary continue to receive intranasal steroid concomitantly? Yes___ No___

Nasal Polyps: Continuation of Therapy (please answer questions 18-24)

24. Is the beneficiary receiving continued clinical benefit from baseline supported by medical records? Yes___ No___
If Yes, please attach medical records.

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406