



Prior Authorization Form
Xolair® (omalizumab)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Xolair®
Quantity \_\_\_\_\_ Refill x \_\_\_\_\_ months
Instructions \_\_\_\_\_
Physician's signature \_\_\_\_\_ Provider NPI: \_\_\_\_\_ MD# \_\_\_\_\_
Date: \_\_\_\_\_ Date medication needed \_\_\_\_\_

Patient Information

Patient's name \_\_\_\_\_
Patient's address \_\_\_\_\_
City, State, Zip: \_\_\_\_\_
Patient's phone # \_\_\_\_\_
Patient's ID#: \_\_\_\_\_ DOB \_\_\_\_\_

Prescriber Information

Prescribing physician \_\_\_\_\_
Office address \_\_\_\_\_
City, State, Zip: \_\_\_\_\_
Office contact \_\_\_\_\_
Office # \_\_\_\_\_ Fax# \_\_\_\_\_

Upon approval, delivery is available. Complete section below.

No Delivery Requested / Delivery Requested
Physician Supply, authorization only [Flex series] / Physician's office / Patient's home
Member Pick up at pharmacy if benefit available / Preferred Vendor: \_\_\_\_\_

\*\*A copy of the prescription must accompany the medication request\*\*

1. PHYSICIAN'S SPECIALTY (required, specify all) \_\_\_\_\_

2. DIAGNOSIS FOR DRUG REQUESTED

Moderate to severe asthma
Other (specify) \_\_\_\_\_

3. PATIENT'S INFORMATION:

a. Has the patient had a positive skin test or in vitro reactivity to a perennial aeroallergen?
b. Has the patient failed, is unresponsive to, or inadequately controlled on inhaled corticosteroids?
c. Has the patient failed, is unresponsive to, or inadequately controlled on inhaled corticosteroids in combination with a long-acting beta agonist?
d. Does the patient have a baseline serum IgE level between 30 IU/ml and 700 IU/ml?

4. PATIENT HISTORY

New start / Continued Treatment

Please list any previous or current therapies related to the diagnosis:

Table with columns: Drug name, Dates, Duration

Please add any other supporting medical information that may be useful in the decision-making process:

FAX: (888) 671-5285 or EMAIL: FSS\_Standard\_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL