Pharmacy Prior Approval Request for

Monoclonal Antibodies: Xolair- NASAL POLYPS

Beneficiary Information

1. Beneficiary Last Name: ______________________________ 2. First Name: ____
3. Beneficiary ID #: _____________________ 4. Beneficiary Date of Birth: ____________________ 5. Beneficiary Gender: ______

Prescriber Information

6. Prescribing Provider NPI #: ____
7. Requester Contact Information - Name: ____________________________ Phone #: ______________________ Ext. _________

Drug Information

8. Drug Name: _________________________________ 9. Strength: __________________ 10. Quantity Per 30 Days: ___________
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Nasal Polyps: New Therapy

1. Is the beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary weigh between 30kg (66lbs) and 150kg (330lbs)? ☐ **Yes** ☐ **No** **Beneficiary's Weight:** ______
3. Does the beneficiary have an IgE level above 30IU/ml? ☐ **Yes** ☐ **No** Please list level: ______________________
4. Does the beneficiary have a diagnosis of Nasal Polyps? ☐ **Yes** ☐ **No**
5. Has the beneficiary tried and failed monotherapy with nasal steroids? ☐ **Yes** ☐ **No**
6. Will the beneficiary continue to receive intranasal steroid concomitantly? ☐ **Yes** ☐ **No**

Nasal Polyps- Continuation of Therapy (please answer questions 1-7)

7. 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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/