carolina complete health

Pharmacy Request for Prior Approval - Monoclonal Antibody Therapy - Xolair

Recipient Information

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

Allergic Asthma: New Therapy

1. Is the member 6 years of age or older? ☐ Yes ☐ No

2. Does the beneficiary weigh between 20 kg (44 lbs) and 150 kg (330 lbs)? ☐ Yes ☐ No **Beneficiary's Weight: _____**

3. Does the member have a diagnosis of Asthma? ☐ Yes ☐ No

4. Has the member 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 member 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 member used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days?

☐ Yes ☐ No

7. Has the member 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 member have an IgE level above 30IU/ml? ☐ Yes ☐ No

Please list level: _____

Allergic Asthma: Continuation of Therapy

9. While on Xolair, has the member had continued clinical benefit and reductions in asthma exacerbations from baseline?

☐ Yes ☐ No

10. What is the member's current asthma status? _____

11. What has been the member's response to Xolair treatment? _____

12. What is the member's current smoking status: _____

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Chronic Idiopathic Urticaria: New Therapy

13. Is the member 12 years of age or older? ☐ Yes ☐ No

14. Does the member have a diagnosis of moderate to severe chronic idiopathic urticaria? ☐ Yes ☐ No

15. Does the member 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 anser 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

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.