

NC Pharmacy Prior Approval Request for 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. 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

Allergic Asthma: New Therapy

1. Is the patient 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 patient 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 patient 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 patient used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days?
 Yes No
7. 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
8. Does the patient have an IgE level above 30IU/ml? Yes No Please list level: _____

Allergic Asthma: Continuation of Therapy

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

Chronic Idiopathic Urticaria: New Therapy

13. Is the patient 12 years of age or older? Yes No
14. Does the patient have a diagnosis of moderate to severe chronic idiopathic urticaria? Yes No
15. Does the patient 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

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.