



**XOLAIR PRIOR AUTHORIZATION  
PHYSICIAN FAX FORM**

**Only the prescriber may complete this form.**

The following documentation is **REQUIRED** for prior authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Kansas Web site at [www.bcbsks.com](http://www.bcbsks.com)

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

**INSURANCE INFORMATION**

BCBS ID Number:	Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PRIOR AUTHORIZATION INFORMATION**

1. Does the patient have a diagnosis of moderate to severe allergic asthma? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the patient have a documented positive skin test to a perennial aeroallergen? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Is the allergen the trigger for the asthma? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is the patient currently treated with Xolair? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, see Renewal Request Section at the bottom of the page.  
If no, continue to Initial Request Section.

**INITIAL Request Section**

1. Please check all that apply concerning the patient's medication history:

**Current use**  Orally inhaled corticosteroids  Long-acting beta 2-agonist  Leukotriene Modifier  Theophylline

**Previous use**  Orally inhaled corticosteroids  Long-acting beta 2-agonist  Leukotriene Modifier  Theophylline

Explain why discontinued \_\_\_\_\_

**Please indicate if the patient has contraindications to any of the following**

Orally inhaled corticosteroids  Long-acting beta 2-agonist  Leukotriene Modifier  Theophylline

2. Does the patient experience exacerbations of asthma symptoms requiring increased inhaled corticosteroid dosing, daily use of  $\beta$ 2-agonist rescue medication and/or systemic corticosteroids?.....  Yes  No

**RENEWAL Request Section**

1. Have the patient's asthma symptoms improved since the initiation of Xolair therapy?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is the patient still exposed to the perennial aeroallergen? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the patient's weight changed requiring a dose adjustment?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**DOSING INFORMATION**

Patient weight \_\_\_\_\_ kg Date patient's weight was measured \_\_\_\_\_

Patient pre-treatment IgE test result \_\_\_\_\_ IU/mL Date patient's IgE was measured \_\_\_\_\_

Requested Xolair dose \_\_\_\_\_ mg subcutaneously, every \_\_\_\_\_ weeks

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 1305 Corporate Center Drive  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130 Phone: 866.469.5660**

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