



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

Today's Date: _____

PATIENT INFORMATION

Form with fields for Patient Name (First/Last), M, DOB, Patient Address, City, State, Zip, and Patient Telephone.

INSURANCE INFORMATION

Form with fields for BCBS ID Number and Group Number.

PHYSICIAN/CLINIC INFORMATION

Form with fields for Prescriber Name, Physician NPI#, Specialty, Contact Name, Clinic Name, Clinic Address, City, State, Zip, Phone #, and Secure Fax #.

PRIOR AUTHORIZATION INFORMATION

Form with 4 questions regarding asthma diagnosis, skin tests, allergen triggers, and current treatment with Xolair.

INITIAL Request Section

Form with 2 questions about medication history and contraindications, including checkboxes for various asthma treatments.

RENEWAL Request Section

Form with 3 questions about symptom improvement, allergen exposure, and weight changes since starting Xolair.

DOSING INFORMATION

Form with fields for Patient weight, Date patient's weight was measured, Patient pre-treatment IgE test result, Date patient's IgE was measured, and Requested Xolair dose.

Please fax or mail this form to: Prime Therapeutics LLC, Clinical Review Department, 1020 Discovery Road, No. 100, Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 Phone: 866.469.5660

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential.

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