Independence

Today's date: _____ **Intended date of injection:** _____

Prior Authorization Form – Xolair®

Buy-and-bill requests for this drug should be submitted through NaviNet®.

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Check one: ☐ New start ☐ Continued treatment

Patient information (please print)	Physician information (please print)	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

This drug will be delivered to the requesting physician.

**** A copy of the prescription must accompany the medication request for delivery.****

1) Diagnosis for drug requested (must include ICD-10): _____

2) Patient medical information

For allergic asthma

a. Has the patient had a positive skin test or in vitro reactivity to a perennial aeroallergen? ☐ Yes ☐ No

b. Has the patient failed, is unresponsive to, or inadequately controlled on high-dose inhaled corticosteroids in combination with a long-acting beta agonist? ☐ Yes ☐ No

c. What is the patient's baseline serum IgE level (drawn prior to initiation of Xolair)? _____IU/mL
Please fax baseline serum IgE level along with this form.

For chronic urticaria

a. Does the patient have a documented failure, contraindication, or intolerance to at least a 4-week trial of a second-generation non-sedating H1 antihistamine (e.g., Zyrtec®, Allegra®, Claritin®) at the maximum recommended dose? If yes, list the drug/dose/duration: _____ ☐ Yes ☐ No

b. Does the patient have a documented failure, contraindication, or intolerance to at least a 2-week trial of any of the drugs listed below? Check all that apply, and list the drug(s)/dosage(s)/duration(s) on the line provided below: ☐ Yes ☐ No

- ☐ Leukotriene receptor antagonist (e.g., Singulair®); _____
- ☐ Histamine H2-receptor antagonist (e.g., Pepcid®, Zantac®); _____
- ☐ First-generation (sedating) H1 antihistamine (e.g., Benadryl); _____
- ☐ Systemic glucocorticosteroids administered as short-term therapy; _____
- ☐ Substitution to a different second-generation non-sedating H1 antihistamine; _____
- ☐ Cyclosporine, in addition to the non-sedating H1 antihistamine; _____

3) Prescription information

Quantity_____ refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Please fax this completed form to 215-761-9580.

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