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Medicare Part D Prescription Coverage Request Form - *XOLAIR*

View our formulary on line at https://www.blueshieldca.com/med_formulary

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

Important Note: Expedited Decisions

If the standard decision time of 72 hours or less may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited (fast) decision can be requested.

☐ CHECK THIS BOX IF A DECISION NEEDS TO BE GIVEN WITHIN 24 HOURS.

Date of Request:

Physician Information	**Patient Information**
Physician's Name: ☐ PCP; ☐ Specialist: _____ Office contact:_____ Phone#: ( ) Facsimile #: ( )	Patient's Name: Patient's Address: Blue Shield ID#: Birthdate: Patient's height/weight: Drug Allergies:

STRENGTH:	QUANTITY:	EXPECTED LENGTH OF THERAPY:
DIRECTIONS:		
DIAGNOSIS:		ICD-10 CODE:

PATIENT CLINICAL INFORMATION

1. Is this a new prescription? ☐ Yes ☐ No. If no, please provide date therapy was started.

2. What is the physician's specialty?

3. What other medication(s) will be used with Xolair?

_____

_____

_____

_____

_____

FAX form to: 1(888)697-8122 | **Pharmacy Services Phone #: 1(800)535-9481**

Effective: 2/1/2019

For allergic asthma:

Initial Requirements

4. What is the patient's serum IgE level? _____cells/mcL; Date drawn: _____

5. In the past 12 months, select all that apply:

- ☐ Patient had at least two asthma exacerbations requiring systemic corticosteroids
- ☐ Patient had at least one acute asthma-related ER visit(s)
- ☐ Patient had at least one asthma-related inpatient admission
- ☐ Four or more unscheduled outpatient visits for asthma

6. Has the patient tried at least one inhaled corticosteroid (ICS) in combination with a long-acting beta agonist (LABA)?

- ☐ Yes, name of medications: _____
- ☐ No, what is the rationale for using Xolair:

_____

_____

Reauthorization

7. Is there documentation the patient has had a positive clinical response to Xolair therapy? ☐ Yes ☐ No

8. Has the patient had a reduction in the number of asthma exacerbations requiring oral systemic corticosteroids? ☐ Yes ☐ No

9. Has the patient had a reduction in asthma symptoms (e.g. decreased number of sick days, improvement in physical activity, reduction in PRN use of short acting beta agonist)? ☐ Yes ☐ No

10. Has the patient had a reduction in dose and frequency of inhaled steroids compared to baseline? ☐ Yes ☐ No

For chronic urticaria:

11. Has the patient had a complete diagnostic work-up to rule out an underlying cause of chronic urticaria? ☐ Yes ☐ No

12. Has the patient had a history of persistent symptoms of hives and itching for the past six months? ☐ Yes ☐ No

13. Has the patient been treated with hydroxyzine or doxepin? ☐ Yes ☐ No

14. Has the patient been treated with a maximally tolerated dose of a second-generation antihistamine (e.g. Allegra, Zyrtec, Claritin, Clarinex)? ☐ Yes ☐ No

If no, what is the rationale for not using anti-histamines:

_____

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Additional information we should consider *(attach any supporting documents)*:

_____

_____

_____

_____

Provider Signature:	**Date:**

An Independent Member of the Blue Shield Association

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