

XOLAIR

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

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

PRESCRIBER/CLINIC INFORMATION

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

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]) <input type="checkbox"/> Chronic rhinosinusitis with nasal polyps (CRSwNP) <input type="checkbox"/> IgE-mediated food allergy <input type="checkbox"/> Moderate to severe persistent asthma <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. What is the patient’s weight? _____ (kg) 2. What is the patient pretreatment serum IgE level? _____ (IU/mL) 3. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was the treatment started on samples? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was the patient using under medical drug benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain risk: _____ _____ 4. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____ 5. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient’s age for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____ 6. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., asthma: allergist, immunologist, pulmonologist; CRSwNP: otolaryngologist, allergist, immunologist, pulmonologist; CSU: allergist, dermatologist, immunologist; IgE-mediated food allergy: allergist, immunologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

7. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada, Actemra, Adalimumab, Adbry, Amjevita, Arcalyst, Avsola, Avtozma, Benlysta, Bimzelx, Cibirgo, Cimzia, Cinqair, Cosentyx, Cyltezo, Dupixent, Ebglyss, Enbrel, Entyvio, Fasenra, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Ilaris, Ilumya, Imuldosa, Inflectra, Infliximab, Kevzara, Kineret, Leqselvi, Litfulo, Nemludio, Nucala, Olumiant, Omlyclo, Omvoh, Opzelura, Orenzia, Otezla, Otezla XR, Otulfi, Pyzchiva, Remicade, Renflexis, Rhapsido, Riabni, Rinvoq, Rituxan, Rituxan Hycela, Ruxience, Saphnelo, Selarsdi, Siliq, Simlandi, Simponi, Simponi ARIA, Skyrizi, Sotyktu, Spevigo subcutaneous injection, Stelara, Steqeyma, Taltz, Tezspire, Tofidence, Tremfya, Truxima, Tyenne, Tyruko, Tysabri, Ustekinumab, Velsipity, Wezlana, Xeljanz, Xeljanz XR, Xolair, Yesintek, Yuflyma, Yusimry, Zeposia, Zymfentra]? Yes No
- If yes, please specify agent: _____
- If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? Yes No
- If no, is there support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required)? Yes No
- If yes, please submit submitted copy of clinical trials, phase III studies, guidelines.
8. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____
- _____
- _____

For moderate to severe persistent asthma requests:

9. Please select the patient's age and answer the corresponding questions.
- 6 to less than 12 years of age
- Does the patient have a pretreatment IgE level that is 30 IU/mL to 1300 IU/mL? Yes No
- Does the patient weigh 20 kg to 150 kg? Yes No
- 12 years of age or over
- Does the patient have a pretreatment IgE level that is 30 IU/mL to 700 IU/mL? Yes No
- Does the patient weigh 30 kg to 150 kg? Yes No
10. Has the patient's allergic asthma been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen? Yes No
11. Does the patient have a history of uncontrolled asthma while on asthma control therapy (e.g., inhaled corticosteroid [ICS]/long-acting beta-2 agonist [LABA] combination therapy) as demonstrated by one or more of the following? Select all that apply
- Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months
- Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months
- Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered
- A baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted
- None of the above
12. Is the patient currently treated for at least 3 months AND has been adherent for 90 days within the past 120 days with ONE of the following: 1) A long-acting beta-2 agonist (LABA), 2) A long-acting muscarinic antagonist (LAMA), 3) A leukotriene receptor antagonist (LTRA), 4) Theophylline. Please note, chart notes are required for review. Yes No
- If yes, please submit chart notes.
- If no, does the patient have an intolerance or hypersensitivity to ONE long-acting beta-2 agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist (LTRA), or theophylline? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL long-acting beta-2 agonists (LABA) AND long-acting muscarinic antagonists (LAMA)? Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

13. Is the patient currently being treated with a biologic immunomodulator agent that is FDA labeled or supported in compendia (AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use) for the treatment of asthma (including the requested agent)? Yes No

If yes, is the patient currently treated with an inhaled corticosteroid for at least 3 months that is adequately dosed to control symptoms AND has been adherent for 90 days within the past 120 days?

Please note, chart notes are required for review. Yes No

If yes, please submit chart notes.

If no, is the patient currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days? Please note, chart notes are required for review. Yes No

If no, does the patient have an intolerance or hypersensitivity to ONE inhaled corticosteroid? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL inhaled corticosteroids? ... Yes No

If yes, please specify FDA labeled contraindication: _____

If no, is the patient currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days? Please note, chart notes are required for review. Yes No

If yes, please submit chart notes.

If no, does the patient have an intolerance or hypersensitivity to ONE inhaled corticosteroid? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL inhaled corticosteroids? Yes No

If yes, please specify FDA labeled contraindication: _____

14. Will the patient continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent? Yes No

15. Is the requested quantity (dose) based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 375 mg every 2 weeks? Yes No

For chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU])

16. Has the patient had hives and itching for more than 6 weeks? Yes No

17. Has the prescriber evaluated the patient to determine if the patient is currently treated with medication known to cause or worsen urticaria (e.g., NSAIDs) in order to reduce urticaria risk? Yes No

18. Is the patient currently treated with a second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)? Yes No

If yes, please specify agent: _____

If yes, will the patient continue second-generation H1-antihistamine therapy in combination with the requested agent? Yes No

If no, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to ALL second-generation H1-antihistamines? Yes No

If yes, please explain intolerance/hypersensitivity/contraindication: _____

If no, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to ALL second-generation H1-antihistamines? Yes No

If yes, please explain intolerance/hypersensitivity/contraindication: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

19. Has the patient tried and had an inadequate response to the FDA labeled maximum dose of ONE second-generation H1-antihistamine (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)? Yes No
- If yes, has the patient tried and had an inadequate response to a maximally tolerated dose of ONE second-generation H1-antihistamine titrated up to 4 times above the FDA labeled maximum dose after at least a 2-week duration of therapy? Yes No
- If no, is there support that the patient cannot be treated with a second-generation H1-antihistamine at a dose above the FDA labeled maximum dose? Yes No
- If yes, please explain why patient cannot use dose over FDA max: _____
- _____
- If no, does the patient have an intolerance or hypersensitivity to ONE second-generation H1-antihistamine? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL second-generation H1-antihistamines? Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____
- If no, does the patient have an intolerance or hypersensitivity to ONE second-generation H1-antihistamine? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL second-generation H1-antihistamines? Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____
20. Is the requested quantity (dose) within FDA labeling AND does NOT exceed 300 mg every 4 weeks? Yes No
- For chronic rhinosinusitis with nasal polyps (CRSwNP)**
21. Does the patient have a pretreatment IgE level that is 30 IU/mL to 1500 IU/mL? Yes No
22. Does the patient weigh 30 kg to 150 kg? Yes No
23. Does the patient have at least TWO of the following symptoms consistent with chronic rhinosinusitis (CRS)? Yes No
- Nasal discharge (rhinorrhea or post-nasal drainage)
 - Nasal obstruction or congestion
 - Loss or decreased sense of smell (hyposmia)
 - Facial pressure or pain
24. Has the patient had symptoms consistent with chronic rhinosinusitis (CRS) for at least 12 consecutive weeks? Yes No
25. Has the patient's diagnosis been confirmed by ONE of the following: Yes No
- Anterior rhinoscopy
 - Nasal endoscopy
 - Computed tomography (CT) of the sinuses
26. Has the patient tried and had an inadequate response to ONE intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) after at least a 4-week duration of therapy? Yes No
- If no, does the patient have an intolerance or hypersensitivity to ONE intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva)? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL intranasal corticosteroids? Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

27. Is the patient currently treated with one of the following standard nasal polyp maintenance therapies? Select all that applies.

Nasal saline irrigation

Fluticasone nasal spray

Mometasone nasal spray

Sinuva

Other (please specify): _____

No standard nasal polyp maintenance therapy

If yes, will the patient continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent? Yes No

28. Is the requested quantity (dose) based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 600 mg every 2 weeks? Yes No

For IgE-mediated food allergy

29. Does the patient have a pretreatment IgE level that is 30 IU/mL to 1850 IU/mL? Yes No

30. Does the patient weigh 10 kg to 150 kg? Yes No

31. Does the patient have an IgE-mediated food allergy confirmed by an allergy diagnostic test (e.g., skin prick test, serum specific IgE test, oral food challenge)? Yes No

32. Will the requested agent be used for the emergency treatment of allergic reactions, including anaphylaxis? Yes No

33. Will the patient avoid known food allergens while treated with the requested agent? Yes No

34. Does the patient have epinephrine on hand for emergency treatment? Yes No

35. Is the requested quantity (dose) based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 600 mg every 2 weeks? Yes No

For renewal requests:

36. Has the patient had clinical benefit with the requested agent? Yes No

For moderate to severe persistent asthma

37. Is the patient currently treated within the past 90 days and is compliant with asthma control therapy (e.g., inhaled corticosteroids [ICS], ICS/long-acting beta-2 agonist [ICS/LABA], leukotriene receptor antagonist [LTRA], long-acting muscarinic antagonist [LAMA], theophylline)? Please note, chart notes are required for review. Yes No

If yes, please submit chart notes.

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road
 Eagan, MN 55121

TOLL FREE

Phone: **BCBSIL: 800.285.9426**
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

Fax: 877.243.6930

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. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.