



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Xolair Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#		DEA#	
Office Address:	City:	State:		Zip Code:	
Office Contact:	Office Phone		Office Fax:		
Dispensing Pharmacy Information					
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:		
Requested Medication Information					
What medication(s) has member tried and failed for this diagnosis? Please specify:					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one):		Diagnosis:		ICD-10 Code:	
Yes No					
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Directions for Use:	Strength:		Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:		
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____			
Clinical Information					
<input type="checkbox"/> Moderate to Severe Asthma					
Classification of asthma as uncontrolled OR inadequately controlled as defined by ONE of the following:		<input type="checkbox"/> Poor symptom control (ACQ score >1.5 or ACT score <20)		<input type="checkbox"/> 2 or more bursts of systemic steroids for at least 3 days each in previous 12 months	
		<input type="checkbox"/> Asthma-related emergency TX (ER visit, hospital admit OR unscheduled DR's office visit for nebulizer OR other urgent TX)			
		<input type="checkbox"/> Airflow limitation (after appropriate bronchodilator withhold FEV1 <80% predicted defined as less than lower limit of normal)			
		<input type="checkbox"/> Member is currently dependent on oral steroids for TX of asthma			
<input type="checkbox"/> Baseline (pre-omalizumab TX) serum total IgE level ≥ 30 IU/mL AND ≤ 1500 IU/mL		<input type="checkbox"/> Member is currently dependent on oral steroids for TX of asthma		<input type="checkbox"/> Positive skin test OR in vitro reactivity to a perennial aeroallergen	
<input type="checkbox"/> Use of ONE MAX-dosed COMBO ICS-LABA [fluticasone propionate-salmeterol (AirDuo, Advair), budesonide-formoterol (Symbicort)]		<input type="checkbox"/> Use of ONE high-dose ICS [ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]		<input type="checkbox"/> Use of one ADD'L asthma controller (LABA - olodaterol (Striverdi) OR indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]	
Is the member receiving Xolair with Nucala, Fasenna, Cinqair OR Dupixent?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Requests ONLY					

Documentation of positive clinical response as demonstrated by ONE of the following:	<input type="checkbox"/> Reduction in frequency of exacerbations	<input type="checkbox"/> Decreased utilization of rescue medications
	<input type="checkbox"/> Reduction in severity OR frequency of asthma-related symptoms (wheezing, SOB, coughing)	<input type="checkbox"/> Increase in % predicted FEV1 from pre-TX baseline
<input type="checkbox"/> Xolair is used in COMBO with an ICS-containing controller medication	Is the member receiving Xolair with Nucala, Fasenna, Cinqair OR Dupixent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chronic Idiopathic Urticaria		
<input type="checkbox"/> Member remains symptomatic despite at least a 2-week trial of OR HX of C/I or intolerance with TWO H1-antihistamines [Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]		
<input type="checkbox"/> Member remains symptomatic despite at least a 2-week trial of OR HX of C/I or intolerance to the following taken in combination: 2 nd generation H1-antihistamine [Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]		
Member has ONE of the following:	<input type="checkbox"/> A different 2 nd generation H1-antihistamine [Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]	
	<input type="checkbox"/> H2-antihistamine [Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]	
	<input type="checkbox"/> 1 st generation H1-antihistamine [Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]	
	<input type="checkbox"/> Leukotriene modifier [Singulair (montelukast)]	
<input type="checkbox"/> Renewal Requests ONLY		
Is there documentation of positive clinical response to therapy (reduction in exacerbations, itch severity, hives)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.		
Signature affirms that information given on this form is true and accurate and reflects office notes.		
Prescribing Provider's Signature: _____		Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.