

XOLAIR® FAX REQUEST FORM

(BCBSNC Corporate Medical Policy DRU4190)

PROVIDER INFORMATION		PATIENT INFORMATION	
PRESCRIBER NAME	PROVIDER ID/TAX ID <small>(out of state must have Tax ID)</small>	PATIENT NAME	
CONTACT PERSON		BCBSNC ID	
PHONE	FAX	DATE OF BIRTH	
PRESCRIBER ADDRESS:		CITY	STATE
		ZIP	

Specialty Pharmacy Utilized: _____

Medication Requested: Xolair Frequency of Injections: _____

Please check the appropriate box to indicate if this request is for initial coverage or for continuation of current coverage and answer the corresponding questions.

Initial Coverage - Please check all that apply:

The member must meet all the following criteria:

- ≥ 12 years of age
- Moderate to severe persistent asthma
- Positive skin test or in vitro reactivity to a perennial aerollergen
- IgE level ≥ 30 but ≤ 700 IU/ml

In addition must meet one of the following:

- Symptoms are inadequately controlled despite use of medium dose of inhaled corticosteroids (QVAR, Pulmicort, Aerobid, Flovent, Asmanex, Azmacort) with combination long acting **B2** agonist (Foradil, Serevent) or leukotriene modifier (Singulair, Accolate, Zyflo) for at least three months

OR

- There is a requirement for chronic administration of systemic corticosteroids (betamethasone, cortisone, dexamethasone, hydrocortisone, methylprednisolone, prednisolone, prednisone, triamcinolone) or high dose inhaled corticosteroids (QVAR, Pulmicort, Aerobid, Flovent, Asmanex, Azmacort) to maintain adequate control

* Initial coverage is for a 6 months period.

Continued Coverage

- The patient has responded well to Xolair, including improved symptom control and decreased exacerbations.

* Continued coverage is for a 12 month period.

I certify that, to the best of my knowledge, the information above is accurate.

Prescriber's
Signature Required: _____ Date _____

Fax completed form to 1-800-795-9403

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