

**XOLAIR® PRIOR AUTHORIZATION  
PHYSICIAN FAX FORM**



The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit the PrimeWest Health System web site at [www.primewest.org](http://www.primewest.org).

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	M:	Patient's Telephone #:	DOB (mm/dd/yyyy):
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**INSURANCE INFORMATION**

Member's Insurance ID Number:	Member's Insurance Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

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

**PRIOR AUTHORIZATION INFORMATION**

Does the patient have a diagnosis of moderate to severe allergic asthma? .....  Yes  No  
 Does the patient have a documented positive skin test to a perennial aeroallergen? .....  Yes  No  
 Is the allergen the trigger for the asthma? .....  Yes  No  
 Is the patient currently treated with Xolair? .....  Yes  No  
 If yes, see Renewal Request Section at the bottom of the page.  
 If no, continue to Initial Request Section.

**INITIAL Request Section**

1. Please check all that apply concerning the patient's medication history:

**Current use**  Orally inhaled corticosteroids  Long-acting beta 2-agonist  Leukotriene Modifier  Theophylline  
**Previous use**  Orally inhaled corticosteroids  Long-acting beta 2-agonist  Leukotriene Modifier  Theophylline

Explain why discontinued \_\_\_\_\_

**Please indicate if the patient has contraindications to any of the following**  
 Orally inhaled corticosteroids  Long-acting beta 2-agonist  Leukotriene Modifier  Theophylline

2. Does the patient experience exacerbations of asthma symptoms requiring increased inhaled corticosteroid dosing, daily use of  $\beta$ 2-agonist rescue medication and/or systemic corticosteroids? .....  Yes  No

**RENEWAL Request Section**

1. Have the patient's asthma symptoms improved since the initiation of Xolair therapy? .....  Yes  No  
 2. Is the patient still exposed to the perennial aeroallergen? .....  Yes  No  
 3. Has the patient's weight changed requiring a dose adjustment? .....  Yes  No

**DOSING INFORMATION**

Patient weight \_\_\_\_\_ kg Date patient's weight was measured \_\_\_\_\_  
 Patient pre-treatment IgE test result \_\_\_\_\_ IU/mL Date patient's IgE was measured \_\_\_\_\_  
 Requested Xolair dose \_\_\_\_\_ mg subcutaneously, every \_\_\_\_\_ weeks

**Please fax or mail this form to:**  
 PrimeWest Health System  
 Clinical Review Department  
 1020 Discovery Road, No. 100  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130 Phone: 800.711.9866**

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