MERCYCARE HEALTH PLANS

PRIOR AUTHORIZATION FAX REQUEST FORM **- FAX to 608-758-7726**

FOR **omalizumab (Xolair)**

Name	DOB
MercyCare ID#	

NOTICE: This form is to be used for:
Prior Approval of omalizumab

FOR MERCYCARE USE ONLY

MCHP Group Name:#

MCHP Group #: *Effective date:*

Tier 2 3

GNRC's: *Transaction #*

Entered by:

Drug Name omalizumab	Strength	Dosing	Quantity
		Duration of Therapy Anticipated	

Patients will be approved for omalizumab if they meet the following criteria. **Please check the appropriate box and send supporting documentation.**

- ❑ Ordered by a pulmonologist or allergist
- ❑ Indicated for patient > 12 years of age
- ❑ IgE value of > 30
- ❑ Positive skin test or in vitro testing (blood test for allergen-specific IgE antibodies such as the RAST) for one or more perennial aeroallergens (ie, house dust mite, animal dander, cockroach, feathers, mold spores)
- ❑ Symptoms have not been adequately controlled by high dose inhaled corticosteroids after at least 6 months of therapy. Inadequate control demonstrated by: hospitalization for asthma, systemic corticosteroids, increasing need fro short acting inhaled beta 2 agonists
- ❑ Compliant use of a leukotriene inhibitor
- ❑ Reasonable attempt to minimize environmental factors
- ❑ Approvals are limited to a 3-month period and will be reevaluated: Prescriber must provide medical records to document response.
  - RX history review for compliance and rescue medication use
  - Decrease in corticosteroid use.

Physician Signature:	Date	Phone #	Fax #
Physician Name (Please Print)	Specialty	Location	

Approved thru: / /

3—6—9—12 months

Denied

Records Requested

Rx History

Redirect

Medical Director Signature:_____/___/___

12/10/04