

XOLAIR (omalizumab)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. Is the patient 12 years of age or older? Y N
2. What is the primary diagnosis? Asthma Other (specify): _____
3. What is the severity of the patient's asthma? Mild intermittent Mild persistent
 Moderate persistent Severe persistent
4. Is the patient taking a short-acting beta2-agonist for rescue therapy? Y N
5. Will Xolair be used in combination with other medications for long-term control of asthma? Y N
6. Please document the pre-treatment IgE level. _____ IU/ml
7. Is patient currently receiving Xolair therapy? Y N
[If answer is yes, skip to question 13.]
8. Does patient have positive skin or in vitro reactivity to at least 1 perennial aeroallergen or multiple seasonal allergens? Y N

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| 9. Is the patient's dose of Inhaled Corticosteroid (ICS) optimized without adequate asthma control? | Y | N |
| 10. Is the patient optimizing the use of a long acting beta2-agonist? | Y | N |
| 11. Is the patient optimizing the use of leukotriene modifier or theophylline as an alternative? | Y | N |
| 12. Has the patient been adherent/persistent with prescribed asthma treatments? | Y | N |

Only answer below questions if patient is currently receiving Xolair.

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| 13. Has the patient's asthma control improved on Xolair therapy? | Y | N |
| 14. If asthma has not improved, is there a clinical reason for the lack of improvement? | Y | N |
| 15. If yes, what is the reason? _____ | | |

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::