

XOLAIR (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group#:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services?
Note: Check guidelines at this point. If PA meets the Close As D scenario, continue with clinical questions. If not, no more questions are required and Close As B. Y N
2. Is the patient 12 years of age or older? Y N
3. Does the patient have a diagnosis of moderate to severe persistent allergic asthma? Y N
4. Did the patient test positive to at least one perennial aeroallergen by a skin test (e.g., prick/puncture test, intracutaneous test) or a blood test (e.g., RAST or similar)? Y N
5. Is or was the pre-treatment IgE level of the patient greater than or equal to 30 and less than or equal to 700 IU/mL? Y N
6. Is the patient using a short-acting beta2-agonist for rescue therapy? Y N

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7. Is the patient currently using oral inhaled corticosteroids at maximum dose(s)? Y N
8. Is the patient currently using a long-acting inhaled beta2-agonist? Y N
9. Is the patient currently using a leukotriene modifier? Y N
10. Has the patient received Xolair in the previous 30 days?
[If the answer to this question is yes, then skip to question 12.] Y N
11. Is the patient's asthma inadequately controlled despite the regular use of inhaled corticosteroids at maximum dose(s)? Y N
12. Will Xolair be used as monotherapy? Y N
13. Will Xolair be administered in a controlled healthcare setting with access to emergency medications (e.g., anaphylaxis kit) if needed and allowing for adequate supervision following administration? Y N
14. Will the patient be provided a prescription for an epinephrine self-injection pen for patient use in the event of a delayed allergic and/or anaphylactic reaction outside of a controlled healthcare setting? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature: 	Date:
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