



Xolair® (omalizumab) Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information call 314-214-8282 or 800-647-2240.

Patient Name: _____

Today's Date: ____/____/____

Patient Pharmacy ID: _____
(located on bottom right of insurance card)

Date of Birth: ____/____/____

Requesting Physician: _____
(Please print)

Specialty: _____

Office Contact Person: _____

Phone #: (____)____-____ ext ____

Medication/dose Requested: _____

Fax #: ____ (____)____-____

Expected Duration of Therapy: _____

ICD-9 _____

- | | | |
|--|-----|----|
| 1. Is the patient 12 years of age or older? | YES | NO |
| 2. Has the patient been evaluated by an asthma specialist (allergist, immunologist, or pulmonologist)? | YES | NO |
| 3. Does the patient have a diagnosis of moderate persistent asthma? | YES | NO |
| 4. Does the patient have a diagnosis of severe persistent asthma? | YES | NO |
| 5. Has the patient failed a treatment regimen that included the following
Corticosteroid, which one _____
Leukotriene modifier, which one _____
Inhaled long-acting bronchodilator, which one _____ | YES | NO |
| 6. Has the patient had a positive skin test or in vitro reactivity to common aeroallergens
(e.g. dust mites, pet dander, cockroach)? | YES | NO |
| 7. Is the patient's pre-treatment serum IgE level between 30 IU/ml and 700 IU/ml? | YES | NO |
| 8. Does the patient's weight and IgE levels fall within the following dosing parameters? | YES | NO |

Xolair Dosage

Pre-treatment serum IgE (IU/ml)	Body Weight (kg)			
	30-60	>60-70	>70-90	>90-150
30-100	150 mg q 4 wks	150 mg q 4 wks	150 mg q 4 wks	300 mg q 4 wks
> 100-200	300 mg q 4 wks	300 mg q 4 wks	300 mg q 4 wks	225 mg q 2 wks
> 200-300	300 mg q 4 wks	225 mg q 2 wks	225 mg q 2 wks	300 mg q 2 wks
> 300-400	225 mg q 2 wks	225 mg q 2 wks	300 mg q 2 wks	Do not dose
> 400-500	300 mg q 2 wks	300 mg q 2 wks	375 mg q 2 wks	
> 500-600	300 mg q 2 wks	375 mg q 2 wks	Do not dose	
> 600-700	375 mg q 2 wks	Do not dose		

Physician's Signature: _____

Date: ____/____/____

For Mercy Health Plans use only: Approved Length of Approval _____
Denied Reason for Denial _____

Reviewer's Signature: _____ Date Reviewed: ____/____/____

Override Entered in Caremark CCMS for _____ - _____ by _____

Office Notified on _____; at _____ am/pm; by _____ spoke to _____