mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

Xolair
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
What medication(s) has member tried and failed for this diagnosis? Please specify:			
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:		☐ Yes	☐ No
Directions for Use:	Strength:	Dosage Form:	
	Quantity: / Day Supply:	Duration of Therapy/Use:	

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information

☐ **Moderate to Severe Persistent Asthma**

Does member have a positive skin test OR in-vitro reactivity to perennial allergen (dust mite, animal dander, cockroach, etc.)?	☐ Yes	☐ No	Is immunoglobulin E (IgE) between 30 and 1300 IU/mL?	☐ Yes	☐ No
Has member been compliant with medium to high dose ICS + LABA for 3 months OR other controller medications (LTRA or theophylline), if intolerant to LABA?				☐ Yes	☐ No

Asthma symptoms are poorly controlled on 1 of above regimens as defined by ANY of the following:	☐ Daily use of rescue medications	☐ Nighttime symptoms occurring more than once per week	☐ At least 2 exacerbations in last 12 months requiring additional medical treatment (systemic corticosteroids, ER visits or

			hospitalization)		
Will member be receiving Nucala, Fasenra, Cinqair OR Dupixent?				☐ Yes	☐ No
☐ **RENEWAL Requests ONLY**					
Has member demonstrated clinical improvement?	☐ Yes	☐ No	Was there decreased use of rescue medications or systemic corticosteroids?	☐ Yes	☐ No
Was there a reduction in number of ER visits or hospitalizations?	☐ Yes	☐ No	Was member compliant with asthma controller medications?	☐ Yes	☐ No
☐ **Chronic Urticaria**					
Is member currently receiving H1 antihistamine therapy?	☐ Yes	☐ No	Was there failure of a 4-week trial with high dose cetirizine, loratadine or fexofenadine?	☐ Yes	☐ No
There was failure of a 4-week trial of at least THREE of the following combinations:	☐ H1 antihistamine + Leukotriene inhibitor (montelukast or zafirlukast)				
	☐ H1 antihistamine + H2 antihistamine (ranitidine or cimetidine)				
	☐ H1 antihistamine + Doxepin				
	☐ 1st generation + 2nd generation antihistamine				
☐ **RENEWAL Requests ONLY**					
Has member demonstrated adequate symptom control such as decreased itching?				☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.
Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.