



Fax completed prior authorization request form to 855-247-3677 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/rbha-forproviders/pharmacy](http://www.mercycareaz.org/providers/rbha-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:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
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:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Directions for Use:		Strength:		Dosage Form:	
		Quantity:	Day Supply:	Duration of Therapy/Use:	
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> <b>Urgent</b> – 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					
<input type="checkbox"/> <b>Moderate to Severe Persistent Asthma</b>					
Does member have a positive skin test OR in-vitro reactivity to perennial allergen (dust mite, animal dander, cockroach, etc.)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is immunoglobulin E (IgE) between 30 and 1300 IU/mL?	
				<input type="checkbox"/> Yes	<input type="checkbox"/> 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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma symptoms are poorly controlled on 1 of above regimens as defined by ANY of the following:		<input type="checkbox"/> Daily use of rescue medications	<input type="checkbox"/> Nighttime symptoms occurring more than once per week	<input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>RENEWAL Requests ONLY</b>			
Has member demonstrated clinical improvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was there decreased use of rescue medications or systemic corticosteroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there a reduction in number of ER visits or hospitalizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was member compliant with asthma controller medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Chronic Urticaria</b>			
Is member currently receiving H1 antihistamine therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was there failure of a 4-week trial with high dose cetirizine, loratadine or fexofenadine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
There was failure of a 4-week trial of at least THREE of the following combinations:	<input type="checkbox"/> H1 antihistamine + Leukotriene inhibitor (montelukast or zafirlukast)		
	<input type="checkbox"/> H1 antihistamine + H2 antihistamine (ranitidine or cimetidine)		
	<input type="checkbox"/> H1 antihistamine + Doxepin		
	<input type="checkbox"/> 1 <sup>st</sup> generation + 2 <sup>nd</sup> generation antihistamine		
<input type="checkbox"/> <b>RENEWAL Requests ONLY</b>			
Has member demonstrated adequate symptom control such as decreased itching?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.</b>			

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

**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 800-564-5465 to check the status of a request.