Trillium Health Resources
Pharmacy Prior Approval Request for

Monoclonal Antibodies: Xolair

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Xolair** 2. Strength: _____ 3. Quantity per 30 Days _____
4. Length of Therapy (**in Days**): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365

Clinical Information

Allergic Asthma: New Therapy

1. Is the member 6 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member weigh between 20kg (44lbs) and 150kg (330lbs)? ☐ **Yes** ☐ **No** **Member's Weight: _____**
3. Does the member have a diagnosis of Asthma? ☐ **Yes** ☐ **No**
4. Has the member used inhaled corticosteroids in the past 45 days and have excessive use of short-acting beta-agonists in the past 60 days? ☐ **Yes** ☐ **No**
5. Has the member used inhaled corticosteroids in the past 45 days and have short-term oral steroid use in the past 45 days?☐ **Yes** ☐ **No**
6. Has the member used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days? ☐ **Yes** ☐ **No**
7. Has the member had a percutaneous skin test or RAST allergy test in the past 12 months indicating reactivity to at least one perennial aeroallergen? ☐ **Yes** ☐ **No**
8. Does the member have an IgE level above 30IU/ml? ☐ **Yes** ☐ **No** **Please list level:** _____

Allergic Asthma: Continuation of Therapy

9. While on Xolair, has the member had continued clinical benefit and reductions in asthma exacerbations from baseline? ☐ **Yes** ☐ **No**
10. What is the member's current asthma status? _____
11. What has been the member's response to Xolair treatment? _____
12. What is the member's current smoking status: _____

Chronic Idiopathic Urticaria: New Therapy

13. Is the member 12 years of age or older? ☐ **Yes** ☐ **No**
14. Does the member have a diagnosis of moderate to severe chronic idiopathic urticaria? ☐ **Yes** ☐ **No**
15. Does the member continue to remain symptomatic despite treatment with at least two (2) H1 antihistamines AND one leukotriene modifier? ☐ **Yes** ☐ **No**
16. Is Xolair being prescribed by or in consultation with an allergy specialist? ☐ **Yes** ☐ **No**

Chronic Idiopathic Urticaria: Continuation of Therapy (please answer questions 13-17)

17. Is the member receiving continued clinical benefit from baseline supported by medical records? ☐ **Yes*** ☐ **No**
    ***If Yes, please attach medical records**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277