**Trillium Health Resources**
**Pharmacy Prior Approval Request for**

# Monoclonal Antibodies: Xolair – NASAL POLYPS

**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 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

**Clinical Information**

**Nasal Polyps: New Therapy**

1. Is the member 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member weigh between 30kg (66lbs) and 150kg (330lbs)? ☐ **Yes** ☐ **No**
   **Member's Weight**: _____
3. Does the member have an IgE level above 30IU/ml? ☐ **Yes** ☐ **No**
   **Please list level**: _____
4. Does the member have a diagnosis of Nasal Polyps? ☐ **Yes** ☐ **No**
5. Has the member tried and failed monotherapy with nasal steroids? ☐ **Yes** ☐ **No**
6. Will the member continue to receive intranasal steroid concomitantly? ☐ **Yes** ☐ **No**

**Nasal Polyps- Continuation of Therapy (please answer questions 1-7)**

7. 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**