CIGNA®
Pharmacy Services
Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- Xolair (omalizumab) -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:
☐ Xolair (omalizumab) ☐ Other (*please specify*):

Dose and Quantity: Duration of therapy: J-Code:

Where will this medication be obtained?
☐ CIGNA Tel-Drug *(CIGNA's nationally preferred specialty pharmacy)*
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

Clinical Data:
Which is the patient's diagnosis?

☐ Asthma, allergic, with stated cause ☐ Asthma, allergic, not otherwise specified ☐ Other (*please specify*):

Does the patient have moderate/severe persistent asthma? ☐ Yes ☐ No

Has the patient had a positive skin test or in-vitro reactivity to a perennial aeroallergen? ☐ Yes ☐ No

Is the patient inadequately controlled with inhaled corticosteroids? ☐ Yes ☐ No

Will the patient be on another controller medication (such as a long-acting beta agonist or leukotriene receptor antagonist during treatment with Xolair)? ☐ Yes ☐ No
If YES, please specify which medications:

Additional pertinent information:

CIGNA HealthCare's coverage position on this and other medications may be viewed online at:
http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.

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