COVENTRY
Health Care

XOLAIR (Omalizumab) PRIOR AUTHORIZATION FORM

The following Coverage Policy applies to all non-Medicare health benefit plans.

Coverage Policy: Xolair is covered for patient at least 12 years of age with severe persistent asthma who have evidence of reversible disease, when recommended by allergist, immunologist or pulmonologists and there is evidence of specific allergic sensitivity to a perennial aeroallergen, after inadequate control despite at least 12 month trial of standard therapy and member is non-smoker, with a weight < 150kg and IgE levels >30 and < 700 IU/ml and the patient has tried an failed conventional immunotherapy or immunotherapy is not indicated.

Medicare requests will be reviewed under CMS guidelines, National and/or Local Determinations.

PLEASE SEND COMPLETED FORM TO COVENTRY HEALTH CARE – PHARMACEUTICAL SERVICES

FAX: 1-866-603-5534 PHONE: 1-800-546-4603

Requesting Physician:	Office Contact:
Office Fax Number:	Phone Number:
Office Address:	
MEMBER INFORMATION	
Patient Name:	DOB:
Member ID#:	Date of Request:

MEDICATION INFORMATION

	Please indicate patient's diagnosis and complete the required fields relating to previous therapies tried. **NOTE: This form will not be reviewed unless it is accompanied by medical records.**
1.	**Unscheduled office visits/ER visits in the last 12 months:_____** **ICU stays or hospitalization in the last 12 months:_____**
2.	**Change in FEV_1 as a result of short-acting bronchodilator challenge:_____%**
3.	**Please list past treatment trials:** Drug(s):_____ Date(s) used:_____ Therapeutic Outcome:_____ Drug(s):_____ Date(s) used:_____ Therapeutic Outcome:_____ Drug(s)_____Date(s) used:_____Therapeutic Outcome:_____ Drug(s)_____Date(s) used:_____Therapeutic Outcome:_____
4.	**Patient smoker: ☐ yes ☐ No.**
5.	**Patients weight: _____**
6.	**IgE level:_____ Date:_____**

Additional comments:

Physician's Signature:

CHCH 2011-13 (5/11)

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