



# XOLAIR REQUEST FORM

Prior Authorization Request for WellCare of Georgia Medicaid  
FAX to 1-866-455-6558 WellCare Pharmacy - Injectable Infusion Department

Complete each section legibly and completely (include any additional necessary medical records or laboratory results)

|            |       |     |     |  |                 |               |  |     |  |
|------------|-------|-----|-----|--|-----------------|---------------|--|-----|--|
| Member ID# |       |     |     |  | Date Submitted  |               |  |     |  |
| Name       |       |     |     |  | Provider ID#    |               |  |     |  |
| Address    |       |     |     |  | Name            |               |  |     |  |
| City       | State |     | Zip |  | Address         | State         |  | Zip |  |
| Phone      | SS #  |     |     |  | City            | Fax           |  |     |  |
| Height     | Wt    | DOB |     |  | Phone           | Alternate Fax |  |     |  |
| Dx         | ICD9  |     |     |  | Alternate Phone | Contact       |  |     |  |

**Diagnosis**  Primary  Secondary **ICD-9 493.\_\_\_\_\_ (Complete 5<sup>th</sup> digit to indicate status asthmaticus condition)** **Specialty:**  Pulmonologist  Allergist

|                                                                                        |                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <b>ICD-9 _____</b> | <b>NIH Asthma Severity Classification</b><br><input type="checkbox"/> Severe Persistent<br><input type="checkbox"/> Mild Persistent<br><input type="checkbox"/> Moderate Persistent<br><input type="checkbox"/> Mild Intermittent |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                       |                                                                                    |                                                                                 |                                                                        |                                                                                        |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <b>Current Concomitant Therapies</b><br><i>(Check all that apply)</i> | <input type="checkbox"/> Short Acting Beta Agonist<br>Drug _____<br>Duration _____ | <input type="checkbox"/> Inhaled Corticosteroid<br>Drug _____<br>Duration _____ | <input type="checkbox"/> Oral Steroids<br>Drug _____<br>Duration _____ | <input type="checkbox"/> Combination therapy (LAB/ICS)<br>Drug _____<br>Duration _____ |
|                                                                       | <input type="checkbox"/> Long Acting Beta Agonist<br>Drug _____<br>Duration _____  | <input type="checkbox"/> Leukotriene Modifier<br>Drug _____<br>Duration _____   | <input type="checkbox"/> Immunotherapy<br>Drug _____<br>Duration _____ | <input type="checkbox"/> Other (specify)<br>Drug _____<br>Duration _____               |

Is patient compliant with use of controller medications (moderate doses of inhaled corticosteroids plus a long acting beta-agonist or leukotriene inhibitor) during the past three months?  Yes  No

In the past 12 months, has the patient had ≥ 3 incidents where controller medication failed, resulting in treatment with oral/ or injected corticosteroids, emergency room/urgent center or clinical office visit, or hospital admission?  Yes  No

|                                                     |                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Lab Results</b><br><i>(Send copy of results)</i> | Test Date _____<br>IgE test results _____ IU/ml<br><i>(Patients with IgE levels &gt; 700 or &lt;30 are not candidates for Xolair treatment)</i> | <b>Positive</b> <input type="checkbox"/> Skin or <input type="checkbox"/> RAST test to a <b>perennial aeroallergen</b><br><i>(check allergens tested)</i><br><input type="checkbox"/> Dust Mites <input type="checkbox"/> Dog or Cat <input type="checkbox"/> Cockroach<br><input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ |
|                                                     | Peak Flow: _____ % of predicted with _____ % variability <b>FEV1</b> _____ <b>FEV1/FVC</b> _____                                                |                                                                                                                                                                                                                                                                                                                                                      |

**Prescription Type** **New Start**  **Continued Tx**  **Drug Allergies** NKDA

|                            |                                                                                                   |                  |         |         |                                                                                                                                     |
|----------------------------|---------------------------------------------------------------------------------------------------|------------------|---------|---------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Dosage</b>              | Xolair Dose Determination by Baseline Serum IgE Level and Body Weight (Package Revised July 2007) |                  |         |         | <b>NOTE:</b><br>Doses above the shaded cells are given every 4 weeks; doses within the gray shading are administered every 2 weeks. |
|                            | Pre-treatment Serum IgE (IU/ml)                                                                   | Body Weight (kg) |         |         |                                                                                                                                     |
| <b>Date</b>                |                                                                                                   | 30-60            | > 60-70 | > 70-90 | >90-150                                                                                                                             |
| _____                      | 30-100                                                                                            | 150              | 150     | 150     | 300                                                                                                                                 |
| _____                      | >100-200                                                                                          | 300              | 300     | 300     | 225                                                                                                                                 |
| <b>Patient Weight (kg)</b> | >200-300                                                                                          | 300              | 225     | 225     | 300                                                                                                                                 |
| _____                      | >300-400                                                                                          | 225              | 225     | 300     | <b>NOT FDA APPROVED</b>                                                                                                             |
| _____                      | >400-500                                                                                          | 300              | 300     | 375     |                                                                                                                                     |
| _____                      | >500-600                                                                                          | 300              | 375     |         |                                                                                                                                     |
| _____                      | >600-700                                                                                          | 375              |         |         |                                                                                                                                     |

**DOSE:** \_\_\_\_\_ mg/dose subcutaneously every \_\_\_\_\_ weeks

**Dispense**  1 month(s) supply **Refill** \_\_\_\_\_ times

**PHYSICIAN SIGNATURE**