

**NC DHB Pharmacy Request for Prior Approval -
Monoclonal Antibody Therapy - Xolair**



DMA-3111 v.03

Recipient Information

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:
8. Prescriber DEA #: _____
Requester Contact Information Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: **Xolair** 10. Strength: _____ 11. Quantity Requested: _____
12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

Allergic Asthma: New Therapy

- 1. Is the patient 6 years of age or older? Yes No
 - 2. Does the patient have a diagnosis of Asthma? Yes No
 - 3. Has the patient used inhaled corticosteroids in the past 45 days and have excessive use of short-acting beta-agonists in the past 60 days? Yes No
 - 4. Has the patient used inhaled corticosteroids in the past 45 days and have short-term oral steroid use in the past 45 days? Yes No
 - 5. Has the patient used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days? Yes No
 - 6. Has the patient had a percutaneous skin test or RAST allergy test in the past 12 months indicating reactivity to at least one perennial aeroallergen? Yes No
 - 7. Does the patient have an IgE level above 30IU/ml? Yes No
- Please list level: _____

Allergic Asthma: Continuation of Therapy

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

Chronic Idiopathic Urticaria

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

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

Fax this form to NCTracks at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505