

HEALTHCHOICE XOLAIR REQUEST

Phone 1-800-543-6044 or 1-405-717-8879

Fax # 1-405-717-8947 or 1-405-717-8935

This Information is private and confidential.

Requesting Agency: _____ Date: _____
Address: _____
Contact Person: _____ Phone: _____ Fax #: _____
Patient: _____ DOB: _____
Member's Name: _____ Member's ID#: _____
Physician's Name: _____

Xolair authorization: Below is the information required for the certification of Xolair:

- 1) a diagnosis of moderate to severe persistent asthma (as per NAEPP guidelines);
- 2) a positive skin test or in vitro reactivity to at least one perennial aeroallergen. Positive perennial allergens must be included in submitted documentation;
- 3) a pretreatment serum IgE level between 30-700 IU/ml.;
- 4) failure to respond to documented treatment for moderate persistent asthma:
 - moderated dose ICS (inhaled corticosteroid) or
 - low-moderate dose OCS and long-acting inhaled beta₂agonistOR
failure to respond to documented treatment for severe persistent asthma:
 - high dose inhaled steroid and long-acting inhaled beta₂agonist;
- 5) medication must be prescribed by either a pulmonary or an allergy/asthma specialist;
- 6) documentation of symptoms, including daily coughing, wheezing, or dyspnea and/or exacerbation affecting activity and sleep despite compliance with the highest appropriate dose of inhaled corticosteroids.

CPT/HCPCS Codes Utilized: _____

Number of Treatments Requested: _____

Start Date _____ End Date _____ Approved _____ Date _____
Extension #1 _____ End Date _____ Approved _____ Date _____

***** **FOR HCMD USE ONLY (Do Not Write Below This Line)** *****

COMMENTS

These benefits are applicable only if the patient is eligible for the Employees Group Insurance Program and are subject to **ALL POLICY PROVISIONS**. Please Remember to verify benefits and eligibility by calling 1-800-782-5218.

MEDICARE PATIENTS: If the Employees Group Insurance Program is supplement, all services requested must be approved by Medicare.