Xolair

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. What is the diagnosis?
   - ❑ Allergic asthma
   - ❑ Chronic idiopathic urticaria (CIU)
   - ❑ Other _____

2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis.

Section A: Allergic Asthma

3. Is this request for initial therapy or for continuation of therapy?
   - ❑ Initial therapy with Xolair, *skip to #5*
   - ❑ Continuation of therapy with Xolair

4. Has the patient's asthma control improved on Xolair therapy as demonstrated by at least ONE of the following? ***Indicate below or mark "None of the above" and no further questions.***
   - ❑ A reduction in the frequency or severity of symptoms and exacerbations
   - ❑ An improvement in FEV_1 since initiation of therapy
   - ❑ A reduction in the daily maintenance oral corticosteroid dose
   - ❑ None of the above

5. Does the patient have positive skin test or *in vitro* reactivity to at least 1 perennial aeroallergen? ❑ Yes ❑ No

6. What is the patient's pre-treatment IgE level? _____ IU/mL ❑ No pre-treatment IgE level

7. Does the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses? ❑ Yes ❑ No
   a) Inhaled corticosteroid
   b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)

Section B: Chronic Idiopathic Urticaria (CIU)

8. Is this request for initial therapy or for continuation of therapy?
   - ❑ Initial therapy with Xolair, *skip to #10*
   - ❑ Continuation of therapy with Xolair

9. Has the patient experienced a positive clinical response (e.g., improved symptoms) since initiation of therapy?
   ❑ Yes ❑ No *No further questions*

10. How long has the patient had a spontaneous onset wheals and/or angioedema? _____ weeks

11. Has the patient been evaluated for other causes of urticaria? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**