

**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.

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**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

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**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<sub>1</sub> 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<sub>2</sub>-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)**