NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval
Monoclonal Antibody Therapy – Xolair

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**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**