

Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

XOLAIR (Omalizumab)

Coverage Criteria / Required Medical Information

Prescriber must be Pulmonologist, Allergist or Immunologist.

Patient is at least 12 years of age **and** has evidence of reversible disease (demonstrates at least 20 percent improvement in PEF with a short-acting bronchodilator challenge); patient has experienced 2 or more asthma exacerbations per month within the last 3 months; positive skin test to at least 1 perennial aeroallergen; baseline IgE level at or above 30 IU/mL; asthma is inadequately controlled despite adherent use of inhaled corticosteroids for at least 6 months; inadequate response to a 3 month trial of a leukotriene modifier and long-acting beta 2-agonist (unless patient demonstrates intolerance to the therapeutic trial) .

Continuation of Therapy

Patients with prior Xolair therapy must demonstrate an improvement in asthma control with use of Xolair.

Exclusion Criteria

Patient is a current smoker, hamster protein hypersensitivity, omalizumab hypersensitivity.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			



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Requested Drug			
XOLAIR	Reason for Request		
Condition/Diagnosis Related			
Clinical Drug/Lab History Pertinent to Request			
Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?	Yes:		No: <input type="checkbox"/>
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: _____ Fax Form to 1-866-481-3704