Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Xolair - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the prescriber a pulmonologist, allergist, immunologist, dermatologist or otolaryngologist?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of moderate to severe persistent asthma?

☐ Yes ☐ No

Q3. Has the patient been previously approved for Xolair?

☐ Yes ☐ No

Q4. Does the patient have greater than 12 percent improvement in forced expiratory volume (FEV1) with at least a 200 mL increase or greater than 20 percent improvement in peak expiratory flow (PEF)? Labs must be attached.

☐ Yes ☐ No

Q5. Is there documented evidence of a decreased dose of steroid requirements and decreased dose of rescue medications?

☐ Yes ☐ No

Q6. Is the patient at least 6 years of age?

☐ Yes ☐ No

Q7. Does the patient have documentation of either of the following: A) patient has tried and failed oral corticosteroids and/or combination therapies (inhaled steroids, long acting beta-agonists, anti-leukotrienes, theophylline), or B) patient is intolerant to oral corticosteroids and/or combination therapies (inhaled steroids, long acting beta-agonists, anti-

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leukotrienes, theophylline)?

☐ Yes ☐ No

Q8. Does the patient have daily asthma symptoms such as coughing, wheezing and dyspnea?

☐ Yes ☐ No

Q9. Does the patient have daily use of rescue inhaler such as a short acting beta2-agonist?

☐ Yes ☐ No

Q10. Does the patient have asthma attacks/exacerbations two or more times per week?

☐ Yes ☐ No

Q11. Does the patient have multiple visits to the emergency room in the previous 12 months?

☐ Yes ☐ No

Q12. Does the patient have one or more nights of nocturnal asthma causing awakening?

☐ Yes ☐ No

Q13. Does the patient have forced expiratory volume (FEV1) greater than 40 percent and less than 80 percent of predicted normal pre-inhaled steroids? Labs must be attached.

☐ Yes ☐ No

Q14. Is there documentation of positive skin test, radioallergosorbent test (RAST), or in vitro reactivity to at least one perennial aeroallergen? Labs must be attached.

☐ Yes ☐ No

Q15. Is there clinical documentation showing of one of the following: A) immunoglobulin E (IgE) levels between 30 and 700 IU/mL for patients 12 years of age and older, or B) IgE levels between 30 and 1300 IU/mL for patients between 6 and 12 years of age? Labs must be attached.

☐ Yes ☐ No

Q16. Does the patient have a diagnosis of chronic idiopathic urticaria (CIU)?

☐ Yes ☐ No

Q17. Does the patient meet either of the following: A) patient remains symptomatic despite H1 antihistamine treatment, B) patient has an intolerance or contraindication to H1 antihistamine treatment?

☐ Yes ☐ No

Q18. Is the patient at least 6 years of age?

☐ Yes ☐ No

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Q19. Does the patient have a diagnosis of nasal polyps?

☐ Yes ☐ No

Q20. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to intranasal corticosteroids and trial of, intolerance to, or contraindication to systemic corticosteroid therapy?

☐ Yes ☐ No

Q21. Is the patient at least 6 years of age?

☐ Yes ☐ No

Q22. Additional Information:

Q23. Requested Duration:

☐ 12 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request