**NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Monoclonal Antibodies: Xolair**

**Beneficiary Information**

1. Beneficiary Last Name: ____________________2. First Name: ________________________________
3. Beneficiary ID #: _____________4. Beneficiary Date of Birth: ________ 5. Beneficiary Gender: ____

**Prescriber Information**

6. Prescribing Provider NPI #: _______________________________________
7. Requester Contact Information –
Name: ___________________________ Phone #: _____________________ Ext.___________________

**Drug Information**

8. Drug Name: _______________________ 9. Strength: ____________ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days):

☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

**Clinical Information**

**Allergic Asthma: New Therapy**
1. Is the patient 6 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary weigh between 20kg (44lbs) and 150kg (330lbs)? ☐ **Yes** ☐ **No**
**Beneficiary's Weight: _________**
3. Does the patient have a diagnosis of Asthma? ☐ **Yes** ☐ **No**
4. 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**
5. 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**
6. Has the patient used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days? ☐ **Yes** ☐ **No**
7. 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**
8. Does the patient have an IgE level above 30IU/ml? ☐ **Yes** ☐ **No** Please list level: ___________________

**Allergic Asthma: Continuation of Therapy**
9. While on Xolair, has the patient had continued clinical benefit and reductions in asthma exacerbations from baseline? ☐ **Yes** ☐ **No**
10. What is the patient's current asthma status?
_____________________________________________________________________________________
_____________________________________________________________________________________


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11. What has been the patient's response to Xolair treatment?

______________________________________________________________________

______________________________________________________________________

12. What is the patient's current smoking status?

______________________________________________________________________

______________________________________________________________________

**Chronic Idiopathic Urticaria: New Therapy**

13. Is the patient 12 years of age or older? ☐ **Yes** ☐ **No**

14. Does the patient have a diagnosis of moderate to severe chronic idiopathic urticaria? ☐ **Yes** ☐ **No**

15. Does the patient continue to remain symptomatic despite treatment with at least two (2) H1 antihistamines AND one leukotriene modifier? ☐ **Yes** ☐ **No**

16. Is Xolair being prescribed by or in consultation with an allergy specialist? ☐ **Yes** ☐ **No**

**Chronic Idiopathic Urticaria: Continuation of Therapy (please answer questions 13-17)**

17. Is the beneficiary receiving continued clinical benefit from baseline supported by medical records? ☐ **Yes** ☐ **No** **If Yes, please attach medical records.**

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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**


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