

**XOLAIR® PREAUTHORIZATION
PHYSICIAN FAX FORM**



An Independent Licensee of the Blue Cross and Blue Shield Association.

The following documentation is **REQUIRED** for preauthorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at www.bcbsne.com

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M.I.:	DOB (mm/dd/yyyy):	Patient Telephone Number:
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INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip:	Phone #:	Secure Fax #:		

PREAUTHORIZATION INFORMATION

1. Patient's diagnosis (ICD-9 code plus description): _____

Does the patient have a documented positive skin test or RAST to a perennial aeroallergen?..... YES NO
 Is the patient currently treated with Xolair? YES NO
 If yes, see Renewal Request Section at the bottom of the page.
 If no, continue to Initial request Section.

INITIAL Request Section

1. Please check all that apply concerning the patient's medication history:

Current use Orally inhaled corticosteroids Long-acting beta 2-agonist Leukotriene Modifier Theophylline
Previous use Orally inhaled corticosteroids Long-acting beta 2-agonist Leukotriene Modifier Theophylline

Explain why _____
 Discontinued _____

Please indicate if the patient has contraindications to any of the following
 Orally inhaled corticosteroids Long-acting beta 2-agonist Leukotriene Modifier Theophylline

Explain why _____

2. Does the patient experience exacerbations of asthma symptoms requiring inhaled corticosteroid dosing, daily use of β 2-agonist rescue medication and/or systemic corticosteroid? YES NO

RENEWAL Request Section

1. Have the patient's asthma symptoms improved since the initiation of Xolair therapy?..... YES NO
 2. Is the patient continuing inhaled corticosteroid therapy?..... YES NO
 If no, please explain _____

3. Has the patient's weight changed requiring a dose adjustment? YES NO

DOSING INFORMATION

Patient weight _____ (kg) Date patient's weight was measured _____

Patient pre-treatment IgE test result _____ IU/mL Date patient's IgE was measured _____

Requested Xolair dose _____ mg subcutaneously, every _____ weeks

Please fax or mail this form to:
 Blue Cross and Blue Shield of Nebraska
 Pharmacy Department - UM
 7261 Mercy Road
 Omaha, NE 68180-0001
Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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