

# Physician XOLAIR® Request Form

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6038** or urgent requests to **866-533-5491**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

**To speak to a representative, call 866-533-5490. Form must be completed for processing.**



Patient's Name: \_\_\_\_\_

Plan ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

Birth date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

NPI #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

To be Administered from: \_\_\_\_\_ to \_\_\_\_\_ or on: \_\_\_\_\_

Current Weight: \_\_\_\_\_ lbs \_\_\_\_\_ kg

Drug Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Sig and Dose: \_\_\_\_\_

ICD-9 Diagnosis Code: \_\_\_\_\_

Naive Therapy

Continuation of Therapy

Is the member/patient currently residing in a Long-Term Care (LTC) facility?  Yes  No

**ASTHMA HISTORY** – Please provide all requested information. For Pulmonary function tests (PFT) may attach PFT reports or indicate below accordingly. FEV<sub>1</sub> reversibility with B2 agonist and FEV<sub>1</sub> of predicted or PEF measurements are required.

1. Date of Diagnosis: \_\_\_\_\_

2. Pulmonary Function Testing

- Most recent FEV<sub>1</sub> % of Predicted \_\_\_\_\_ Date: \_\_\_\_\_ AND FEV<sub>1</sub> % reversibility with B<sub>2</sub> agonist \_\_\_\_\_ Date: \_\_\_\_\_

- Most recent PEF variability \_\_\_\_\_ Date: \_\_\_\_\_ AND % Predicted PEF \_\_\_\_\_ Date: \_\_\_\_\_

3. Severity of Asthma mild  moderate  severe

- Frequency of daytime and nighttime symptoms \_\_\_\_\_

- Additional comments regarding the patient's condition. (e.g. rescue medication usage) \_\_\_\_\_

**Labs** (Please submit a copy of lab result and/or complete the following):  
Pre Xolair®  
Total Serum IgE: \_\_\_\_\_ IU/mL  
Date of labs: \_\_\_\_\_

4. Is the patient receiving any medications (e.g. Beta-blockers, NSAIDS) that could potentially be contraindicated in asthma? \_\_\_\_\_

5. Has the patient recently been hospitalized for an asthma exacerbation while being compliant at least 3 months prior to admission with high dose inhaled corticosteroids and long acting β<sub>2</sub> agonists (e.g. Serevent® and Advair®)? Yes  No

6. If yes, please indicate dates of admission and the severity (e.g. required ventilation, O<sub>2</sub>) of the exacerbation and patient's routine control medications received at that time. Also please include past 2-year history of hospital admission and ER visits. Please attach additional information if necessary:

7. Please indicate the allergen(s) to which the patient has had a positive skin test (e.g. *dermatophagoides farinae*, *dermatophagoides pteronyssinus*, dog, cat, or cockroach) that were triggers for asthma exacerbation(s) that resulted in hospital admissions and/or ER visit:

8. Please indicate which routine control medications the member is currently receiving including drug name, strength, dose and start date as well as if the patient was compliant:

9. What environmental measures have been attempted to avoid asthma allergen triggers and/or a reason for not making attempts to avoid allergen exposure:

**PLEASE FILL OUT THIS SECTION FOR CONTINUATION OF THERAPY ONLY:** (Attach additional information if necessary)

1. Please document clinical improvements in the patient's condition while taking Xolair® (e.g. symptoms, QOL) \_\_\_\_\_