P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Xolair™
(omalizumab)

Therapeutic use: IgE-mediated allergic asthma
Quantity Limit: 750mg/month
Authorization Period: 12 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | | - | | | | | Fax# | | | | - | | | | |

Physician's signature_____ Date signed | | | / | | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Has an allergist or pulmonologist been consulted?	❑ Yes	❑ No
2.	Is the patient diagnosed with moderate to severe asthma with a documented FEV_1 baseline ≥40% and ≤80% of predicted? Please list most recent FEV_1:_____ Date: _____	❑ Yes	❑ No
3.	Has the patient been compliant for at least 3 months on any of the following? Please check those that apply. ❑ Medium dose of ICS + long-acting inhaled bronchodilators OR ❑ Medium-dose ICS + leukotriene antagonist OR ❑ Medium dose ICS + theophylline with therapeutic blood levels OR ❑ High-dose ICS + long-acting inhaled bronchodilators	❑ Yes	❑ No
4.	Despite the above controller regimens, has the patient had continuing symptomatic asthma as defined by each of the criteria below? Please check those that apply. ❑ Need for frequent intermittent (≥2 fills in 6 months) use of oral corticosteroids ❑ One ER visit or hospitalization for asthma exacerbation in the past 6 months ❑ Need for frequent office visits due for asthma evaluation (≥3 visits in 6 months)	❑ Yes	❑ No
5.	Is the patient's IgE level ≥30? Please list IgE level:_____ Date: _____	❑ Yes	❑ No
6.	Does the patient weigh ≤330 lbs (≤150 kg)?	❑ Yes	❑ No
All patients should be evaluated and receive treatment for associated medical conditions that may contribute to incomplete asthma control, including allergic rhinitis, GERD, chronic sinusitis, or nasal polyps.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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