BlueCross BlueShield
Nebraska

XOLAIR® PREAUTHORIZATION PHYSICIAN FAX FORM

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.nebraskablue.com***

Patient Information

Today's Date:

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Patient Telephone Number:

Insurance Information

BCBSNE ID Number:	Group Number:

Physician/Clinic Information

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

Preauthorization Information

Requested Drug Name: ________________________ ICD-10 Diagnosis Code: ________________________

Requested Dose: __________ every ____ weeks. Length of treatment: ____________________

Has this patient been previously treated with Xolair?........ ☐ Yes ☐ No

For allergic asthma only:

a. Has the patient had a positive skin test or RAST to a perennial aeroallergen?........ ☐ Yes ☐ No

b. Has the patient failed, is unresponsive to, or inadequately controlled on high-dose inhaled corticosteroids +/- long-acting beta agonist, leukotriene modifier, or theophylline?........ ☐ Yes ☐ No

If yes, please provide medical history and explain why each medication was discontinued: ________________________

c. Please list baseline serum IgE level:

Date Tested: ____________ Patient Weight (kg): _________ Pre-treatment Serum IgE (IU/mL): ____________

d. Has the patient's weight changed requiring a dose adjustment?........ ☐ Yes ☐ No

e. If this is a renewal, have the patient's asthma symptoms improved since the initiation of Xolair therapy?........ ☐ Yes ☐ No

I. Is the patient continuing inhaled corticosteroid therapy? If no, please explain. ________________________

II. Has the patient's weight changed requiring a dose adjustment?........ ☐ Yes ☐ No

For chronic idiopathic urticaria (CIU) only:

a. Does the patient have a history of chronic idiopathic urticaria for at least six months?........ ☐ Yes ☐ No

b. Does the patient have a documented failure, contraindication, or intolerance to a second generation non-sedating H1 antihistamine (e.g., Zyrtec®, Allegra®, Claritin®) at the maximum recommended dose?........ ☐ Yes ☐ No

If yes, list the drug/dose/duration: ________________________

C. Please provide clinical information and documentation for the use of this medication. ***If this is a renewal, please indicate whether this therapy has resulted in a reduction in symptoms***: ________________________

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
1919 Aksarben Drive • PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877.232.6726
Phone: 877.999.2374

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