BlueCross BlueShield Nebraska

XOLAIR PREAUTHORIZATION REQUEST
POLICY X.19
PREAUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Save time by filling out this preauthorization form electronically at* MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request? **Today's Date:**

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Patient and Insurance Information

Patient First Name:	Patient Last Name:	Middle Initial:	Date of Birth (mm/dd/yyyy):
Patient Address:	City, State, ZIP	Member ID Number:	

Prescriber Information

Prescriber Name:	Prescriber NPI:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, ZIP:	Clinic Phone Number:	Secure Fax Number:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Request for: ☐Xolair Prefilled Syringe ☐Xolair Viral for injection (J2357)

Diagnosis for use:

☐Moderate-to-severe persistent asthma ☐Chronic spontaneous urticaria ☐Nasal polyps

Dose Requested: _____

1. Is the patient currently being treated with the requested medication?..... ☐Yes ☐No
   If yes, is the patient at risk if they change therapy?..... ☐Yes ☐No
2. For diagnosis of moderate-to-severe persistent asthma:
   a. IgE level: _____ Date obtained: _____ Weight: _____
   b. Has allergic asthma been confirmed with skin testing or in vitro reactivity (RAST) testing?..... ☐Yes ☐No
   c. Previously tried inhaled corticosteroids: _____
   d. Previously tried long acting β2-agonist _____
3. For diagnosis of chronic spontaneous urticaria:
   a. Previous 2nd Generation antihistamine trialed: _____
   b. Previous H-2 antihistamine trialed: _____
   c. Previous leukotriene trialed: _____
4. For diagnosis of nasal polyps:
   a. Previously tried intranasal steroids: _____
   b. Has the patient received surgical intervention for nasal polyps?..... ☐Yes ☐No

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

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Phone: 877-999-2374