



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xolair (omalizumab)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	Physician Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the duration of the therapy requested? Less than or equal to 12 months More than 12 months
Q2. Does the patient have evidence of reversible disease? Yes No
Q3. Does the patient have greater than a 12% improvement in FEV1 with at least a 200ml increase? Yes No
Q4. Does the patient have greater than a 20% improvement in PEF? Yes No
Q5. Is there documented evidence of improvement on the patients PFTs? Yes No
Q6. Is there documented evidence of decreased steroid requirements? Yes No
Q7. Deliver to: Physician's Office Home Delivery
Q8. Delivery date needed:

Physician Signature

Date