



**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 note any information left blank or illegible may delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State, Zip:	City, State, Zip:
Member Phone:	

Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

<b>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</b>
Q1. What is the requested duration of therapy? 6 months or less      More than 6 months
Q2. Does the patient have > 12% improvement in FEV1 with at least a 200 ml increase? Labs must be attached. Yes      No
Q3. Does the patient have > 20% improvement in PEF? Labs must be attached. Yes      No
Q4. Is there documented evidence of a decreased dose of steroid requirements (maximum of 1 inhaler per month)? Yes      No
Q5. Is there documented evidence of a decreased dose of rescue medications (maximum of 1 inhaler per month)? Yes      No
Q6. Comments:

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**