Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Xolair

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the request for a new patient with current history of taking Xolair in the last 90 days or is the request for reauthorization of prior approval.

☐ Yes ☐ No

Q2. Has the prescriber provided confirmation of disease stabilization or a positive clinical response?

☐ Yes ☐ No

Q3. Is the drug prescribed by or in consultation with appropriate specialist for indication: a pulmonologist, allergist, immunologist, dermatologist or otolaryngologist?

☐ Yes ☐ No

Q4. Is the Is the patient within the age group listed in the FDA labeling or medically accepted use for the requested indication?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Does the patient have a diagnosis of moderate to severe persistent asthma? If YES, go to 6. If NO, go to 10.

☐ Yes ☐ No

Q6. Are there chart notes showing positive skin test, RAST, or in vitro reactivity to at least one perennial aeroallergen?

☐ Yes ☐ No

Q7. Are there chart notes showing baseline IgE levels greater than or equal to 30 IU/mL?

☐ Yes ☐ No

Q8. Has the patient experienced either of the following within the previous 12 months: (1) at least one asthma exacerbation requiring systemic corticosteroids (e.g., prednisone), or (2) an asthma-related hospitalization?

☐ Yes ☐ No

Q9. Are there chart notes showing that the patient had inadequate response, intolerance, or contraindication to BOTH of the following: 1) medium-to-high-dose inhaled corticosteroid, AND 2) additional controller (i.e., LABA, LAMA, leukotriene modifier, or theophylline)?

☐ Yes ☐ No

Q10. Are there chart notes documenting a diagnosis of chronic spontaneous urticaria (CSU)?

☐ Yes ☐ No

Q11. Are there notes confirming the patient has urticaria lasting more than 6 weeks and other causes of urticaria have been ruled out? If YES, go to 12.

☐ Yes ☐ No

Q12. Does the patient meet either of the following: A) patient remains symptomatic despite treatment with at least one H1 antihistamine, B) patient has an intolerance or contraindication to at least one H1 antihistamine treatment?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q13. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP)?	
☐ Yes	☐ No
Q14. Will the patient be treated with Xolair in combination with intranasal corticosteroids?	
☐ Yes	☐ No
Q15. Has the patient had an inadequate response, intolerance, or contraindication to at least one systemic corticosteroid OR prior surgery for nasal polyps?	
☐ Yes	☐ No
Q16. Are there chart notes documenting a diagnosis of IgE mediated food allergy?	
☐ Yes	☐ No
Q17. Is there documentation showing IgE levels between 30 and 1850 IU/ml?	
☐ Yes	☐ No
Q18. Additional Information:	

_____ _____

Prescriber Signature Date

v2026

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