

# Physician XOLAIR® Request Form

Fax non-urgent requests to PerformRx Pharmacy Services at **877-693-8280** or urgent requests to **877-693-8476**. Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **800-578-0898**. *Form must be completed for processing*



Patient's Name: \_\_\_\_\_ Member ID#: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Physician Signature \_\_\_\_\_ LTC member  Yes  No, Date Admitted \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

To be Administered from: \_\_\_\_\_ to \_\_\_\_\_ or on: \_\_\_\_\_ Current Weight: \_\_\_\_\_ lbs \_\_\_\_\_ kg  
Drug Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Sig and Dose: \_\_\_\_\_ ICD-9 Diagnosis Code: \_\_\_\_\_

Naïve Therapy

Continuation of Therapy

1. Diagnosis: \_\_\_\_\_ ICD-9 Diagnosis Code: \_\_\_\_\_
2. Pulmonary Function Testing  
- Most recent FEV<sub>1</sub> % of Predicted \_\_\_\_\_ Date: \_\_\_\_\_ OR  
- Most recent FEV<sub>1</sub>/FVC \_\_\_\_\_ % Date \_\_\_\_\_
3. Severity of Asthma mild  moderate  severe   
- Frequency of daytime and nighttime symptoms \_\_\_\_\_  
- Additional comments regarding the severity of the patient's asthma \_\_\_\_\_

Labs (Please submit a copy of lab result and/or complete the following):

Pre Xolair®  
Total Serum IgE: \_\_\_\_\_ IU/mL  
Date of labs: \_\_\_\_\_

4. Is the patient receiving any medications (e.g. Beta-blockers, NSAIDS) that could potentially be contraindicated in asthma? \_\_\_\_\_
5. Please indicate which routine control medications the member is currently receiving including drug name, strength, dose and start date as well as if the patient was compliant: \_\_\_\_\_
6. Has the patient recently been hospitalized or visited the ER due to a severe asthma exacerbation while being compliant with high dose inhaled corticosteroids and long acting  $\beta_2$  agonists? Yes  No
7. If yes, please indicate dates of hospital admission and/or ER visit. Please attach additional information if necessary. \_\_\_\_\_
8. Please indicate the allergen(s) to which the patient has had a positive skin test (e.g. *dermatophagoides farinae*, *dermatophagoides pteronyssinus*, dog, cat, or cockroach) that are triggers for their asthma exacerbation(s) \_\_\_\_\_
9. Did the patient receive a full course of immunotherapy? Yes  No  Please comment: \_\_\_\_\_
10. What environmental measures have been attempted to avoid asthma allergen triggers and/or a reason for not making attempts to avoid allergen exposure: \_\_\_\_\_

PLEASE FILL OUT THIS SECTION FOR CONTINUATION OF THERAPY ONLY: (Attach additional information if necessary)

1. Please document clinical improvements in the patient's condition while taking Xolair® (e.g. symptoms, QOL) \_\_\_\_\_