

XOLAIR (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 866-692-2630.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services? Y N
2. Is the patient 12 years of age or older?
[If the answer to this question is no, no further questions are required.] Y N
3. Prior to initiating therapy, does the patient have a diagnosis of moderate to severe persistent allergic asthma inadequately controlled with inhaled corticosteroids?
[If the answer to this question is no, no further questions are required.] Y N
4. Did the patient test positive to at least one perennial aeroallergen by a skin test (e.g., prick/puncture test, intracutaneous test) or a blood test (e.g., RAST or similar)?
[If the answer to this question is no, no further questions are required.] Y N
5. Is or was the pre-treatment IgE level of the patient 30 IU/mL or greater?
[If the answer to this question is no, no further questions are required.] Y N
6. Is the asthma inadequately controlled with an optimal dose of an orally inhaled corticosteroid?
[If the answer to this question is no, no further questions are required.] Y N
7. Will Xolair be used as monotherapy for moderate to severe persistent allergic asthma? Y N

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Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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