



**Phone: 800-842-2015 Fax: 877-837-5922**

<b>PATIENT DATA</b>	Last Name	First Name	Policy Number	Date of Birth	Age
<b>REQUESTING PHYSICIAN DATA</b>	Last Name	First Name	Contact Name	Fax Number ( )	
BCBSLA Provider Number	Area of Practice/Specialty <input type="checkbox"/> Allergist <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Other _____		Name of Place of Treatment	Phone Number ( )	
<b>BILLING DATA</b>	Diagnosis Code(s) (ICD-9): 1) 2)		CPT-4/HCPCS Code	Other Codes	

**DRUG INFORMATION**

<input type="checkbox"/> 150 mg SC every _____ weeks	<input type="checkbox"/> Diluent: 10-cc vial preservative-free sterile water for injection	<b>Anticipated Start Date</b>
<input type="checkbox"/> 225 mg SC every _____ weeks	<input type="checkbox"/> Supplies, syringes and needles for preparation and administration of Xolair	
<input type="checkbox"/> 300 mg SC every _____ weeks	<input type="checkbox"/> Dispense: 1 month supply      Refill _____ times	
<input type="checkbox"/> 375 mg SC every _____ weeks		
<input type="checkbox"/> Other _____ mg every _____ weeks		

**INDICATION / DIAGNOSIS**

<input type="checkbox"/> <b>Initial Request</b> (new start)	<input type="checkbox"/> <b>Continuation Request</b>
<input type="checkbox"/> Severe Persistent	<input type="checkbox"/> Mild Persistent
<input type="checkbox"/> Moderate Persistent	<input type="checkbox"/> Mild Intermittent
	<input type="checkbox"/> Other Indication _____

**PAST TREATMENT HISTORY (Check ALL that apply)**

<input type="checkbox"/> Short Acting Beta Agonist	<input type="checkbox"/> Combination Therapy (LAB/ICS)
<input type="checkbox"/> Long Acting Beta Agonist	<input type="checkbox"/> Other(s) _____
<input type="checkbox"/> Inhaled Corticosteroid	<input type="checkbox"/> Patient's symptoms are inadequately controlled with combo controller therapy or that patient cannot tolerate the medications
<input type="checkbox"/> Leukotriene Modifier	

**LAB DATA**

Yes  No History of positive skin or in vitro reactivity to a perennial aero-allergen  
**Pre-treatment Serum IgE level** \_\_\_\_\_ IU/ML **Test Date** \_\_\_\_\_ **Patient weight** \_\_\_\_\_ (Kg) **Date wt obtained** \_\_\_\_\_

FEV1 / PEF Predicted Value \_\_\_\_\_ %  PEF Variability \_\_\_\_\_ %

**OTHER CLINICAL INFORMATION (Complete and check ALL that apply)**

Yes  No Is this a new diagnosis for this patient?

Yes  No Does the patient have limited physical activity?

Yes  No is the patient experiencing continual symptoms?

Yes  No Is the patient experiencing frequent nocturnal symptoms?

Yes  No Is the patient experiencing frequent exacerbations that affect activity? If yes, list frequency and duration \_\_\_\_\_

Yes  No Has it been confirmed that patient's symptoms are inadequately controlled with combo controller therapy or that patient cannot tolerate the medications?

Yes  No Will the patient be receiving the drug in the physician's office? If no, list name of servicing provider \_\_\_\_\_

**I certify that the rationale for Xolair therapy for Allergic Asthma is necessary for this patient, and I will be supervising the patient's treatment accordingly.**

<b>PHYSICIAN SIGNATURE</b>  _____ Prescribing Physician	<b>DATE</b>  _____
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**Note:** Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

**Incomplete forms will not be processed**