Xolair

Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,
  TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:

SECTION A Please answer the following questions

1. θ Yes θ No Is the diagnosis or indication for the treatment of moderate to severe persistent asthma?
   If "no", proceed to question 5.
2. θ Yes θ No Does the member have a positive skin test OR in vitro reactivity to a perennial aeroallergen (e.g., house dust mite, animal dander, mold spores, etc.)?
3. θ Yes θ No Does the member have a baseline serum IgE greater than or equal to 30 IU/mL?
4. θ Yes θ No Has the member used at least one formulary inhaled corticosteroid (e.g., fluticasone-salmeterol diskus, mometasone-formoterol, etc.) prior to the initiation of Xolair OR are any of the formulary inhaled corticosteroids likely to cause an allergy/adverse reaction or other harm to the member?
5. θ Yes θ No Is the diagnosis or indication for the treatment of symptomatic chronic idiopathic urticaria, refractory to H1 antihistamine (e.g. Benadryl, diphenhydramine, etc.) therapy? ***If "no", proceed to question 7.***
6. θ Yes θ No Has the member used at least one formulary H1 antihistamine (e.g., levocetirizine, desloratadine, etc.) prior to the initiation of Xolair OR are any of the formulary H1 antihistamines likely to cause an allergy/adverse reaction or other harm to the member?

7. θ Yes θ No Is the diagnosis or indication for the prevention of adverse reactions in adults receiving immunotherapy? ***If "no", proceed to question 9.***

8. θ Yes θ No Has the member used at least one conventional therapy (e.g., levocetirizine, desloratadine, prednisone, methylprednisolone, etc.) or aprepitant prior to the initiation of Xolair OR are any of these medications likely to cause an allergy/adverse reaction or other harm to the member?

9. θ Yes θ No Is the diagnosis or indication for the treatment of systemic mastocytosis? ***If "no", proceed to question 11.***

10. θ Yes θ No Has the member used at least one conventional therapy (e.g., levocetirizine, desloratadine, prednisone, etc.) prior to the initiation of Xolair OR are any of the conventional therapies likely to cause an allergy/adverse reaction or other harm to the member?

11. θ Yes θ No Is the diagnosis or indication for the treatment of seasonal or perennial allergic rhinitis?

12. θ Yes θ No Does the member have a positive skin test or in vitro for one or more relevant allergens (e.g., grass, tree, or weed pollen, mold spores, house dust mite, etc.)?

13. θ Yes θ No Has the member used at least one formulary H1 antihistamine (e.g., levocetirizine, desloratadine, etc.) prior to the initiation of Xolair OR are any of the formulary H1 antihistamines likely to cause an allergy/adverse reaction or other harm to the member?

14. θ Yes θ No Is the diagnosis or indication for the treatment of nasal polyps with inadequate response to nasal corticosteroids as add-on maintenance treatment?

15. θ Yes θ No Has the member used at least one formulary nasal corticosteroid (e.g., mometasone, etc.) prior to the initiation of Xolair?

16. θ Yes θ No Is the diagnosis or indication for the reduction of allergic reactions (Type 1) in patients with IgE-mediated food allergies?

Please document the symptoms and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at http://www.scanhealthplan.com