NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Monoclonal Antibodies: Xolair

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Allergic Asthma: New Therapy

1. Is the patient 6 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary weigh between 20kg (44lbs) and 150kg (330lbs)? ☐ **Yes** ☐ **No** **Beneficiary's Weight: _____**
3. Does the patient have a diagnosis of Asthma? ☐ **Yes** ☐ **No**
4. Has the patient used inhaled corticosteroids in the past 45 days and have excessive use of short-acting beta-agonists in the past 60 days ☐ **Yes** ☐ **No**
5. Has the patient used inhaled corticosteroids in the past 45 days and have short-term oral steroid use in the past 45 days? ☐ **Yes** ☐ **No**
6. Has the patient used inhaled corticosteroids in the past 45 days and had an emergency room visit in the past 45 days? ☐ **Yes** ☐ **No**
7. Has the patient had a percutaneous skin test or RAST allergy test in the past 12 months indicating reactivity to at least one perennial aeroallergen? ☐ **Yes** ☐ **No**
8. Does the patient have an IgE level above 30IU/ml? ☐ **Yes** ☐ **No** Please list level: _____

Allergic Asthma: Continuation of Therapy

9. While on Xolair, has the patient had continued clinical benefit and reductions in asthma exacerbations from baseline? ☐ **Yes** ☐ **No**
10. What is the patient's current asthma status? _____
11. What has been the patient's response to Xolair treatment? _____
12. What is the patient's current smoking status: _____

Chronic Idiopathic Urticaria: New Therapy

13. Is the patient 12 years of age or older? ☐ **Yes** ☐ **No**
14. Does the patient have a diagnosis of moderate to severe chronic idiopathic urticaria? ☐ **Yes** ☐ **No**
15. Does the patient continue to remain symptomatic despite treatment with at least two (2) H1 antihistamines AND one leukotriene modifier? ☐ **Yes** ☐ **No**
16. Is Xolair being prescribed by or in consultation with an allergy specialist? ☐ **Yes** ☐ **No**

Chronic Idiopathic Urticaria: Continuation of Therapy (please answer questions 13-17)

17. Is the beneficiary receiving continued clinical benefit from baseline supported by medical records? ☐ **Yes** ☐ **No**
If Yes, please attach medical records

Signature of Prescriber:_____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.