XOLAIR

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES **PHONE 800-979-UPMC (8762)** **FAX 412-454-7722**

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ☐**Brand** ☐**Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐**New medication** ☐**Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did the member show improvement while on therapy?**	☐**Yes** ☐**No**
Diagnosis:		**Date of diagnosis:**	

Please indicate place of administration? ☐Physician's Office ☐Hospital/Facility ☐Patient Home

Please provide facility/provider name and address:

Please indicate how medication will be billed:
☐ Billed directly by the provider via JCODE
Provide JCODE:_____
☐ Billed by a pharmacy and delivered to the provider
☐ Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY

Patient Height (include units)**:**	**Patient Weight** (include units)**:**	**Pretreatment Serum lgE**	☐**Yes** ☐**No**
		If YES, lgE Level **IU/ml**	**Test Date:**

History of positive skin or RAST Test to a perennial allergen AND/OR for seasonal aeroallergens? ☐**Yes** ☐**No**

Is patient currently taking any of the following medications (check all that apply and indicate length of therapy on each):

☐**Short Acting Beta Agonists**	_____	☐**Inhaled Corticosteroids**	_____
☐**Long Acting Beta Agonists**	_____	☐**Immunotherapy**	_____
☐**Oral Steroids**	_____	☐**Leukotriene Modifiers**	_____

☐**Other Medications(Please Specify):**

Has patient been hospitalized due to asthma?	☐**Yes** ☐**No**
Does the member require systemic (oral or parenteral) steroids to control asthma exacerbations	☐**Yes** ☐**No**
Has patient had an increased need for short-acting inhaled beta2 agonists?	☐**Yes** ☐**No**

HISTORY OF FORMULARY MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Trial	Date of Therapy Start Date	Date of Therapy End Date	Strength	Frequency	List adverse reactions/side effects/reason for discontinuing

Please provide any additional information which should be considered in the space below: