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Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Xolair[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
<p>Continuation of therapy: Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (REQUIRED)</p> <hr/> <hr/>

<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Chronic idiopathic urticaria</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
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<p>Clinical Information: Is there presence of contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>For asthma, also answer the following: Select the patient's asthma severity level (select ALL that apply):</p> <p><input type="checkbox"/> Mild <input type="checkbox"/> Intermittent</p> <p><input type="checkbox"/> Moderate <input type="checkbox"/> Persistent</p> <p><input type="checkbox"/> Severe</p> <p><input type="checkbox"/> Other. Please specify: _____</p> <p>Document the patient's weight: _____</p> <p>Document the patient's pre-treatment serum IgE level: _____</p>

<p>Reauthorization: For asthma and/or chronic idiopathic urticaria reauthorization requests, answer the following: Is there documentation of reduction in the patient's symptoms from baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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