Washington State Health Care Authority

Xolair® (Omalizumab) J2357 Request

Please Fax Response to: 1-866-668-1214
Medical Request Coordinator

Please provide the information below. PLEASE PRINT your answers, **attach any supporting documentation,** sign, date, and return to our office as soon as possible to expedite this request. **If we do not receive this information your request will be denied withing thirty (30) days.**

DATE OF REQUEST	PATIENT NAME	PROVIDER ONE CLIENT ID	DATE OF BIRTH

PRESCRIBER	BILLING PROVIDER NPI NUMBER	TELEPHONE NUMBER	FAX NUMBER

DRUG/STRENGTH	DIRECTIONS FOR USE	QUANTITY / DAYS SUPPLY

Xolair (Omalizumab) is indicated for adults and adolescents (12 years of age and above) with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. Xolair has been shown to decrease the incidence of asthma exacerbations in these patients. Safety and efficacy have not been established in other allergic conditions.

1) Diagnosis for which the drug is prescribed: ____________________ . Date of diagnosis: ____________.
2) What is the pre-treatment serum total IgE level (IU/mL)? ________
3) What is the patient's current weight? ________ kg. or ________ lb.
4) Does the patient have allergic asthma? ☐ Yes ☐ No
5) What is the patient's FEV 1% predicted? ________
6) Does the patient have a previous history of urticaria or anaphylaxis? ☐ Yes ☐ No
   If yes, please explain with documentation if necessary.
7) Is the patient currently on inhaled corticosteroids and/or oral steroids? ☐ Yes ☐ No
8) Has the patient had a positive skin test or RAST test to a perennial aeroallergen? ☐ Yes ☐ No (If yes, please send results)

Note: If this is a reauthorization, please submit documentation of safety (i.e., any adverse reactions) and effectiveness (improvement) while on Xolair.

PHYSICIAN SIGNATURE	PHYSICIAN SPECIALTY	DATE

A copy of the prescription must be attached to this request.

Fax to: **1-866-668-1214**
Or mail to: Medical Request Coordinator
PO Box 45535
Olympia, WA 98504-5535

A typed and completed *General Authorization for Information* form (13-835) must be the cover sheet for your request.