

Statement of Medical Necessity for Xolair: Asthma Diagnosis

TO BE COMPLETED BY PHYSICIAN

<u>PHYSICIAN INFORMATION</u>		
Physician Name:		
Address:		
City:	State:	Zip:
Phone: ()		
Fax: ()		

<u>MEMBER INFORMATION</u>		
Member ID Number:		
Member Name:		
Address:		
City:	State:	Zip:
Phone: ()		

Compliance with all of the prior authorization criteria is a condition for payment for this drug by OHCA.

All information must be provided and OHCA may verify through further requested documentation and the member's drug history will be reviewed prior to approval.

1. Detailed description of diagnosis: _____
2. Date diagnosed: _____
3. List daily medications and dose prescribed for the treatment of this diagnosis:
 Drug/Dose: _____ Drug/Dose: _____
 Drug/Dose: _____ Drug/Dose: _____
4. Was a spacer for inhaled medications used? _____ If 'No', why not? _____
5. Compliant on daily inhaled corticosteroids for a minimum of 3 months prior to request? Yes _____ No _____
6. List frequency of: Exacerbations – Number _____ Per _____; AND Nightly Symptoms – Number _____ Per _____
7. List place and dates of asthma related hospitalizations and/or ER visits in the past 6 months:

8. Patients weight: _____ kg; Baseline IgE level: _____ IU/ml; Xolair Dose: _____
9. Asthma reaction due to food or peanut allergy? _____; Or List the perennial aeroallergen _____
10. Prescriber specialty? _____

The above format is to assist the physician to provide medical documentation that OHCA needs to review this request. This information should come directly from the prescriber and NOT the pharmacy provider.

**** Please provide copies of medical documentation supporting the information above.**

Prescriber Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

<http://www.okhca.org>

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p style="text-align: center;">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></p> <p style="text-align: center;"><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error,</i></p>
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