South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Xolair® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

❑ Asthma
❑ Chronic idiopathic urticaria (CIU)
❑ Nasal polyps with inadequate response to nasal steroid
❑ IgE Mediated Food Allergy
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Allergist ❑ Dermatologist ❑ Immunologist ❑ Pulmonologist ❑ Rheumatologist ❑ Other _____
Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For asthma, answer the following:

Does the patient have a positive skin test or in vitro reactivity to a perennial aeroallergen? ❑ **Yes** ❑ **No**
Does the patient have an elevated serum IgE level? ❑ **Yes** ❑ **No**
Are the patient's symptoms inadequately controlled with inhaled corticosteroids? ❑ **Yes** ❑ **No**

For chronic idiopathic urticaria, answer the following:

Does the patient remain symptomatic despite H1 antihistamine treatment? ❑ **Yes** ❑ **No**

For nasal polyps with inadequate response to nasal steroid, answer the following:

Does the patient remain symptomatic despite nasal steroid? ❑ **Yes** ❑ **No**

For IgE mediated food allergy, answer the following:

Dose the patient have a history of an IgE-mediated (Type I) allergic reaction to one or more food allergens? ❑ **Yes** ❑ **No**
Does the patient have a positive skin prick test (SPT) (≥ 4 mm wheal) to identified foods? ❑ **Yes** ❑ **No**
Does the patient have a positive IgE screening (≥ 6 kUA/L) to identified foods? ❑ **Yes** ❑ **No**
Prescriber attests that member has been counseled to continue food allergen avoidance while utilizing omalizumab: ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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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 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.