CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Xolair® (omalizumab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ 493 _____ Asthma ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient is 12 years of age and older ☐ Yes ☐ No
- Patient has a diagnosis of moderate or severe persistent asthma ☐ Yes ☐ No
- Xolair will be used in combination with other medications for long-term control of asthma ☐ Yes ☐ No
- Patient will have a short-acting beta-agonist available for rescue therapy ☐ Yes ☐ No
- Xolair will be given in a controlled health care setting ☐ Yes ☐ No
- Patient will be provided with an epinephrine self-injection pen in case of allergic reaction ☐ Yes ☐ No

For new starts on Xolair therapy

- Patient has a positive skin test or in vitro reactivity to a perennial aeroallergen ☐ Yes ☐ No
- Patient has a pre-treatment IgE level ≥ 30 IU/ml ☐ Yes ☐ No
- Please provide pretreatment IgE level _____ IU/mL
- Patient has asthma symptoms that are inadequately controlled with use of inhaled corticosteroid at the optimal dose ☐ Yes ☐ No
- Patient has symptoms that are inadequately controlled with optimal use of a long acting beta-2 agonist or leukotriene modifier/theophylline ☐ Yes ☐ No
- Patient has been adherent/persistent with prescribed asthma treatments ☐ Yes ☐ No

For continuation of Xolair therapy:

- Patient's asthma control has improved on Xolair treatment ☐ Yes ☐ No
- If no, is there is a documented clinical reason for lack of improvement ☐ Yes ☐ No
- If yes, please provide clinical reason: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Xolair® 150mg vial kits (omalizumab)	☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg ☐ Other: _____	☐ Every 2 weeks ☐ Every 4 weeks ☐ Other: _____		

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)