Capital BLUE

ACRO Pharmaceutical Services

Tel: 800-906-7798
Fax: 877-381-3806
www.acropharmacy.com

XOLAIR® (Omalizumab)
STATEMENT OF MEDICAL NECESSITY

Please complete this form (PRINT) in its entirety and fax it to the number below. Be sure to enclose any necessary documentation, labs, insurance cards, etc.

PATIENT DEMOGRAPHICS

Last Name | First Name | Middle Initial | ☐ M ☐ F

Address | Apt# | City | State | Zip

Home Telephone | Work Telephone | Cell Phone | Email

Date of Birth | Social Security Number | Allergies

INSURANCE INFORMATION

Please include copies of the patient's insurance/drug benefit cards (front and back) to expedite benefit clearance.

Primary Insurance Name | Policy Number | Group Number

Policy Holder | Employer | Insurance Telephone Number

PRESCRIBER INFORMATION

Prescriber's Name | Clinic Name | Specialty

Address | Suite# | City | State | Zip

Contact Name | Telephone | Ext./Direct Telephone | Fax

Email Address | License Number | DEA # | NPI #

CLINICAL INFORMATION

☐ **Initial** Request for an approval for a period of 6 months Date: _____

☐ **Future** Requests every 6 months during treatment Date: _____

Diagnosis: **Primary ICD-D 493.**_____ **Secondary ICD-9** _____

(Please complete 4th and 5th digits to indicate the type of asthma or status asthmaticus condition.)

Is the patient already taking Xolair for this condition? ☐ Y ☐ N If yes, when was Xolair started? __/__/____

Other Asthma Therapies:

☐ Short-acting Beta-agonist
☐ Inhaled Corticosteroids (without LABA)
☐ Long-acting Beta-agonist (without ICS)
☐ Combination Therapy (LABA/ICS)
☐ Leukotriene Modifier
☐ Oral Steroids
☐ Other (specify)

☐ Check if submitting additional comments, progress notes, most recent laboratory evidence and any other clinical documentation related to this request.

☐ Submitting positive skin or RAST test to a perennial aeroallergen (Not required if treatment for more than 6 months)

Pretreatment serum IGE level IU/mL _____ (IgE baseline ≥30 IU/ml) Test Date __/__/____

Patient Weight (divide lb by 2.2 to obtain kg) _____ kg Weight Date __/__/____

Subcutaneously, Every 4 weeks:

Dose: 150 mg/dose _____
300 mg/dose _____

OR

Subcutaneously, Every 2 weeks:

Dose: 225 mg/dose _____
300 mg/dose _____
375 mg/dose _____

Refill ____ **times** **Dispense as written** _____ **(initial)** **Substitution allowed** _____ **(initial)**

Dispense _____ Diluent: 10-cc vial preservative-free Sterile Water for injection, USP; ancillary supplies: 3-cc syringes as needed for reconstitution; 18-gauge needles as needed for reconstitution; 25-gauge needles as needed for administration.

Physician Signature _____ **Date** _____

The medication will be delivered to the physician's office.

Fax completed form to: (877) 381-3806

On behalf of Capital BlueCross, ACRO Pharmaceutical Services LLC assists in the administration of physician-administered specialty medications. ACRO Pharmaceutical Services is an independent company. Capital BlueCross is an Independent licensee of the BlueCross BlueShield Association.

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