



Prescription Drug Coverage Determination Form
Anti-asthmatic monoclonal antibody
Xolair® (omalizumab)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: Date of Birth:
Subscriber ID#:
Address City State Zip Code

Physician Information

Name: Specialty: Tax ID#:
Office Address City State Zip Code
Telephone: Fax: Contact Person

Physician Signature (REQUIRED): Date

Medication Information (requests for non-formulary agents will be considered for
members having a documented failure or contraindication to preferred agents.)

Medication name: J-code:
Dose: Directions:
Expected Duration of Therapy:

Prior Authorization Criteria:

- 1. Is the medication being requested to treat an FDA-approved indication not otherwise
excluded from Part D?
Diagnosis: ICD-9 code
2. Will the patient be placed on Xolair® monotherapy?
3. Has the patient had a positive skin test or in vitro reactivity to common
aeroallergens?
4. Is the patient's pre-treatment serum IgE level between 30 IU/ml and 700 IU/ml?
5. Is the patient 12 years of age or older?
6. Is the patient adequately controlled on inhaled corticosteroids?

Please provide any additional history or medical information that may support coverage
(attach office notes as necessary):

Note: If approved coverage will be as specified in above criteria or through the end of the
year (December 31, 20xx). Some medications may be subject to quantity limitations or
restricted to certain pharmacies.