

**Health New England**  
**Medication Request Form (MRF)/Prescription Request**  
**Xolair® (omalizumab)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

- Prior Authorization Only**
- Prior Authorization and Drug Delivery Request**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Xolair®. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

**Medication Request Information (please complete each section of this form prior to transmittal):**

Patient Information		Physician Information	
<b>Patient Name (required):</b>		<b>Physician Name (required):</b>	
<b>Patient Cell Phone #: ( ) -</b>		<b>Specialty (required):</b>	
<b>Patient HNE ID# (required):</b>		<b>NPI #:</b>	
<b>Patient Date of Birth (required):</b>		<b>HNE Provider #:</b>	
<b>Allergies:</b>		<b>DEA # (required):</b>	
<b>Diagnosis (required):</b>		<b>Telephone #: ( ) -</b>	
		<b>Fax # (required): ( ) -</b>	
Drug Information			
<b>Requested Drug/Strength/Form: Xolair</b> Note: HNE covers a quantity limit of 6 vials per 30 days			
<b>Dose, Directions, and length of treatment (please be specific):</b>		<b>Quantity (per month):</b>	<b>Refills:</b>
<b>Physician Signature:</b>		<b>Date:</b>	
<p><b>Request:</b></p> <p><input type="checkbox"/> Initial Request</p> <p><input type="checkbox"/> Renewal</p> <p><b>Initial Request - Check all that apply:</b></p> <p><input type="checkbox"/> Positive skin prick</p> <p><input type="checkbox"/> RAST test to a perennial aeroallergen</p> <p><input type="checkbox"/> Demonstrated therapeutic failure to an inhaled or oral corticosteroid product combined with a second asthma controller agent such as a long-acting inhaled beta2-agonist</p> <p><input type="checkbox"/> In the past year patient has required an ER visit or required hospitalization related to asthma exacerbation or patient has required one or more pulses of oral corticosteroid use for the treatment of an asthma exacerbation.</p> <p><b>Answer:</b></p> <p>• Baseline IgE serum level _____ Patient weight _____</p> <p>• FEV1/FVC ratio _____</p> <p><b>Renewal - Check all that apply:</b></p> <p><input type="checkbox"/> In previous six months patient has experienced at least a 25% reduction in asthma exacerbations (e.g., hospitalizations, urgent or emergent care visits, use of rescue medications) from their pre-Xolair baseline.</p> <p><input type="checkbox"/> Patient was receiving maintenance therapy with an oral corticosteroid prior to initiation of Xolair</p> <p><input type="checkbox"/> Patient has been able to reduce oral corticosteroid dose by 75% from pre-Xolair baseline or to 5mg/day or less</p> <p><input type="checkbox"/> Patient has been able to reduce inhaled corticosteroid dose by at least 25% from pre-Xolair dose</p>			