



Xolair® (Omalizumab) Injectable Medication
Precertification Request for Subcutaneous Use
(Required every 6 months)

Aetna Precertification Notification
 503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Indicate: Initial Precertification Recertification after Initial Assessment **Today's date:** _____ **Date needed:** _____
Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____
 Phone: _____ Fax: _____ **TIN:** _____ **PIN:** _____
Ship to: Doctor's office Patient Other: _____ Phone: _____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name:	(Circle one): M.D. D.O. N.P. P.A.		
Address:	City:	State:	ZIP:	
Phone:	Fax:	St. Lic. #:	NPI #:	DEA #:
UPIN:	Office Contact Name:		Phone:	
Specialty (Circle one): Allergist Pulmonologist ENT Pediatrician Primary Care Other: _____				

D. DIAGNOSIS INFORMATION (A SELECTION IS REQUIRED IN THIS SECTION)

Primary ICD-9 (Check one and specify when applicable):

<input type="checkbox"/> 493.0 – 493.02 Extrinsic Asthma _____	<input type="checkbox"/> 493.8 Other forms of asthma _____	<input type="checkbox"/> 493.9 – 493.92 Unspecified _____
<input type="checkbox"/> 493.1 – 493.12 Intrinsic Asthma _____	<input type="checkbox"/> 493.81 Exercise induced bronchospasm _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> 493.2 – 493.22 Chronic obstructive asthma _____	<input type="checkbox"/> 493.82 Cough variant asthma _____	<input type="checkbox"/> Secondary ICD-9: _____

E. CLINICAL INFORMATION (NOT REQUIRED IF REQUEST IS FOR RECERTIFICATION AFTER INITIAL ASSESSMENT)

<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient's symptoms been inadequately controlled with any of the following medications for at least 3 months? (Check all that apply and specify name and dose.)	<input type="checkbox"/> Yes <input type="checkbox"/> No Has patient had a total of at least 3 of the following events within the preceding 12 months due to acute asthma exacerbations while on controller medications: a) Visits to the emergency room or urgent care center; b) Hospital admissions; c) Treatments with high dose injectable or oral corticosteroids.
<input type="checkbox"/> Inhaled corticosteroids (Moderate dose w/o LABA) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient using a short-acting beta2-agonist daily?
<input type="checkbox"/> Long-acting beta-agonist (w/o ICS) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient using other medications to treat asthma? (specify) _____
<input type="checkbox"/> Leukotriene inhibitor _____	
<input type="checkbox"/> Combination therapy (LABA/ICS) _____	

F. DIAGNOSTIC TESTS (ALL INFORMATION IN THIS SECTION IS REQUIRED UNLESS REQUEST IS FOR RECERTIFICATION)

<input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have a history of positive skin or RAST test to a perennial aeroallergen?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is patient's peak expiratory flow (PEF) less than 80% of personal best?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is diurnal variation in peak expiratory flow (PEF) greater than 30%?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is patient's forced expiratory volume in 1 second (FEV1) less than 60% predicted?	
What is patient's pretreatment serum IgE level IU/mL? _____ (1.0 kU/L=1.0 IU/mL; 2.4 ng/mL=1.0 IU/mL)	Test Date: _____ (Must be within last 12 months if new to Xolair)
Patient Weight (Must be current): _____ lbs _____ kgs (Divide lbs by 2.2 to obtain kgs)	Weight Date : _____

G. CONTINUATION OF XOLAIR THERAPY (DO NOT FILL OUT THIS SECTION IF THE PATIENT IS NEW TO XOLAIR)

<input type="checkbox"/> Yes <input type="checkbox"/> No Has patient had decreased utilization of rescue medications?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Has patient had decreased frequency of exacerbations? (exacerbations defined by worsening of asthma)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had an increase in percent predicted FEV-1 from pretreatment base line?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a reduction in reported symptoms as evidenced by decreases in frequency or magnitude of one or more of the following symptoms? Sleep disturbance, Night waking, Symptoms upon awakening; Shortness of breath; Wheezing, Heavy breathing, Fighting for air; Chest tightness, Heaviness; Asthma attacks; Difficulty breathing; Coughing, Clearing throat; or Tiredness.	
<input type="checkbox"/> Yes <input type="checkbox"/> No Has patient experienced symptoms of anaphylaxis (bronchospasm, hypotension, syncope, urticaria, and/or angioedema) after administration of Omalizumab?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had exacerbation of asthma upon discontinuation of Xolair therapy?	
Patient Weight (Must be current): _____ lbs _____ kgs (Divide lbs by 2.2 to obtain kgs)	Weight Date : _____

H. PRESCRIPTION (TO BE COMPLETED AS A PRESCRIPTION ORDER IF AETNA SPECIALTY PHARMACY IS DISPENSING PROVIDER)

Xolair 150 mg # _____ vials Inject Xolair (Check one): 150 mg 300 mg sub-q every 4 weeks
 225 mg 300 mg 375 mg sub-q every 2 weeks
 Number of Refills _____
 For each 150 mg Xolair vial shipped, 1 Xolair kit will be included containing 1-10cc vial preservative-free sterile water for injection; USP; 3cc syringes; 18-gauge needles for reconstitution and 25-gauge needles for administration.

Prescriber's Signature _____ **Date:** _____
 (Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order)

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: _____