PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

XOLAIR®
INITIAL/RENEWAL REQUEST FORM

⊘ PLEASE DO NOT STAPLE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

HOW TO COMPLETE THIS FORM:
PLAN MEMBERS — Please complete RED portions of this form.
PHYSICIANS — Please complete BLACK portions of this form.

Don't forget to sign *Part 8 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for this drug. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

PART 1 — PLAN MEMBER TO COMPLETE

Plan member's name	Patient's name (if different than Plan member's name)

Patient's birthdate (mm-dd-yyyy)	Patient's weight	Patient's height	Policy number	ID number

Street address	City	Province	Postal code	Daytime phone number (10 digits)

☐ I'm aware that if I choose to use Xolair®, I will NOT be eligible for concurrent coverage of other biologic medications for asthma.

PART 2 — PHYSICIAN TO COMPLETE

Physician's name	College ID

Street address	City	Province	Postal code

Physician's area of specialty: ☐ Allergist ☐ Respirologist ☐ Dermatologist ☐ Other: _____

I certify the medical information provided is accurate and current:

Physician's signature **X**	Date (mm-dd-yyyy)

PART 3 — DRUG REQUESTED

☐ Omalizumab (Xolair®)	Dosage	Date of initiation (mm-dd-yyyy)	Duration

Indication: ☐ Asthma (please complete Part 4) ☐ Chronic Idiopathic Urticaria (please complete Part 5)

PART 4 — PATIENT INFORMATION for ASTHMA (to be completed by physician)

☐ Patient ≥ 6 years
☐ Moderate to severe persistent asthma
☐ Therapy with Nucala or Fasenra is not appropriate
☐ Positive skin test or in- vitro reactivity to a perennial aeroallergen **(attach report)**
☐ Currently on high dose of inhaled corticosteroid with beta agonist (fast or long acting)
☐ Intolerant to or failed treatment on a leukotriene receptor antagonist or theophylline

Please indicate: IgE levels (IU/ml): _____ Body weight (kg): _____

Number of hospitalizations due to asthma in the past 12 months (before starting Xolair): _____

Number of exacerbations requiring oral corticosteroids or an increase in oral corticosteroids in the past 12 months (before starting Xolair): _____

Approval period: 1 year

PART 5 — PATIENT INFORMATION for CHRONIC IDIOPATHIC URTICARIA (to be completed by physician)

☐ Patient ≥ 12 years of age
☐ Symptomatic Chronic Idiopathic Urticaria (CIU) for at least 6 months
☐ Baseline UAS7 score: _____
Tried and failed (or intolerant to) at least THREE of the following:
- ☐ First generation H1 Antihistamine: _____
- ☐ Second generation H1 Antihistamine (at 4 times recommended dose): _____
- ☐ Montelukast
- ☐ Immunosuppressant: _____

Approval period: 6 months

Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.

PART 6 — PAST and CURRENT THERAPY

Drug 1	Name	Dosing regimen	Start date (mm-dd-yyyy)	End date (mm-dd-yyyy) or currently on
Response to therapy				
Drug 2	Name	Dosing regimen	Start date (mm-dd-yyyy)	End date (mm-dd-yyyy) or currently on
Response to therapy				
Drug 3	Name	Dosing regimen	Start date (mm-dd-yyyy)	End date (mm-dd-yyyy) or currently on
Response to therapy				
Drug 4	Name	Dosing regimen	Start date (mm-dd-yyyy)	End date (mm-dd-yyyy) or currently on
Response to therapy				
Drug 5	Name	Dosing regimen	Start date (mm-dd-yyyy)	End date (mm-dd-yyyy) or currently on
Response to therapy				

PART 7 — RENEWAL

ASTHMA

☐ Decrease in rescue medications for asthma

Number of hospitalizations due to asthma in the past 12 months (while on Xolair)?: _____

Number of exacerbations requiring oral corticosteroids or an increase in oral corticosteroids in the past 12 months (while on Xolair)?: _____

Approval period: 1 year

CIU

1. Measure of disease severity at the end of the previous 24-week treatment course of Xolair — UAS7 score: _____ Date: _____
2. If the patient's UAS7 score recorded above is zero, was this complete symptom control maintained for at least 12 consecutive weeks?
   ☐ Yes ☐ No ☐ Not applicable (UAS7 was not zero)
3. Has Xolair been discontinued due to temporary symptom control? ☐ Yes — answer a) and b) below ☐ No
   a) Date of discontinuation of previous course of Xolair: _____
   b) Current UAS7 score: _____ Date: _____

Approval period: 6 months

PART 8 — ADDITIONAL INFORMATION

PART 9 — MEMBER CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your form.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature	Date (mm-dd-yyyy)
X	