



15 Earhart Drive, Suite 101, Amherst, NY 14221

Xolair® (omalizumab)
Prior Authorization Request Form
complete all fields and pre-Xolair® data column
Fax this form with the patient completed
Health Impact Survey to: (716)-532-7360 or (800)-273-7397

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Form containing patient information (Last Name, First Name, Member ID, etc.), clinical questions (1-10), lab results table, current therapy details, and a table for tracking Xolair therapy over 24 weeks. Includes sections for 'For Internal Use only' with dates and approvals.