UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Monoclonal Antibodies: Xolair- NASAL POLYPS

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____ Provider Fax #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Nasal Polyps: New Therapy

1. Is the beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary weigh between 30kg (66lbs) and 150kg (330lbs)? ☐ **Yes** ☐ **No** **Beneficiary's Weight:** _____
3. Does the beneficiary have an IgE level above 30IU/ml? ☐ **Yes** ☐ **No** Please list level: _____
4. Does the beneficiary have a diagnosis of Nasal Polyps? ☐ **Yes** ☐ **No**
5. Has the beneficiary tried and failed monotherapy with nasal steroids? ☐ **Yes** ☐ **No**
6. Will the beneficiary continue to receive intranasal steroid concomitantly? ☐ **Yes** ☐ **No**

Nasal Polyps- Continuation of Therapy (please answer questions 1-7)

7. Is the beneficiary receiving continued clinical benefit from baseline supported by medical records? ☐ **Yes** ☐ **No**
   If Yes, please attach medical records

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593