Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Monoclonal Antibodies: Xolair – NASAL POLYPS

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

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

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

7. Is the member 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.