PRIOR AUTHORIZATION REQUEST

XOLREMDI

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by increased time above threshold-absolute neutrophil count (TAT-ANC) time the ANC remained at or above 500 cells per microliter), decrease in number of infections and/or warts, and increase in ALC (absolute lymphocyte count)? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
8	What is the diagnosis or indication? [] WHIM Syndrome (warts, hypogammaglobulinemia, infections and myelokathexis) (If checked, go to 9) [] Other (If checked, no further questions)		
9	Does the patient have a genotype-confirmed mutation of chemokine receptor type 4 (CXCR4) consistent with warts, hypogammaglobulinemia, infections and myelokathexis (WHIM) syndrome? ACTION REQUIRED: Submit supporting documentation with genetic testing results. [If no, no further questions.]	Yes	No
10	Does the patient have an absolute neutrophil count (ANC) less than or equal to 400 cells per microliter or absolute lymphocyte count (ALC) less than or equal to 650 cells per microliter? ACTION REQUIRED: Submit supporting documentation. [If no, no further question.]	Yes	No
11	Has the patient tried and failed, or has a contraindication to prophylactic antibiotics for at least one year? [If no, no further questions.]	Yes	No
12	Does the provider attest that the patient tried and failed, or has a contraindication to granulocyte colony-stimulating factors (Neulasta, Nivestym, Zarxio) or	Yes	No

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	intravenous immunoglobulin (IVIG)? [If no, no further questions.]		
13	Is the requested medication prescribed by or in consultation with an immunologist, geneticist, hematologist, or dermatologist? [If no, no further questions.]	Yes	No
14	Does the dose exceed the Food and Drug Administration (FDA) approved dose? (Dosing: Greater than 50 kg: 400 mg once daily, or less than or equal to 50 kg: 300 mg once daily)	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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