

~ **XOLAIR** ~

**Prior Authorization Request Form**

Effective October 2003, Vermont Medicaid established coverage limits and criteria for prior authorization of Xolair. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

**Use this form for Xolair prior authorization requests only.**

**Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549**

**Prescribing Physician:**

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_

Contact Person at Office: \_\_\_\_\_

**Beneficiary:**

Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Patient Diagnosis: \_\_\_\_\_

**If requesting prescriber is not a pulmonologist, allergist, or immunologist, has one of these specialties been consulted on this case?  Yes  No**

**Specialist name:** \_\_\_\_\_ **Specialist Type:** \_\_\_\_\_

**Pharmacy (if known):** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **&/or FAX:** \_\_\_\_\_

**List all previous therapies (inhaled corticosteroid, second generation antihistamine, leukotriene receptor antagonist, long-acting beta-agonist) tried and failed for this condition:**

Therapy	Reason for discontinuation	Dates Utilized
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Has the member tested positive to at least one perennial aeroallergen by a skin test (i.e. RAST, CAP, intracutaneous test)? Y / N**

**Please explain:** \_\_\_\_\_

**Is the member's IgE level  $\geq 30$  and  $\leq 700$  IU/ml? Y / N**

**Please provide IgE level:** \_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **Date of this request:** \_\_\_\_\_