



Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

XOLAIR.1
FORM#27
C: 12.14

Agency of Human Services

~XOLAIR~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for Xolair, it will be necessary for the prescriber to telephone or complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-5366 or Phone: 1-844-679-5363

Prescribing physician:

Name: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____
Specialty: _____

Beneficiary:

Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Pharmacy Name _____
Pharmacy Phone: _____ Pharmacy Fax: _____
Patient Diagnosis: Moderate/Severe Persistent Asthma
 Other: _____

If requesting prescriber is not a pulmonologist, allergist or immunologist, date of last visit to one (required yearly):

Specialist name: _____ **Specialist Type:** _____ **Date:** _____

Initial Prior Authorization Request: Please complete all portions of form below

Renewal PA Request: Has patient shown marked clinical improvement **Yes** **No**

List all previous therapies tried and failed for this condition:

Therapy	Specific Drug	Reason or Discontinuation
Inhaled Corticosteroid		
Chronic Oral Corticosteroid		
Leukotriene Receptor Antagonist		
Long-Acting Beta Agonist		

Has the member tested positive to at least one perennial aeroallergen by a skin or blood test (i.e. RAST, CAP, intracutaneous test)? **Yes** **No**

Please explain _____

Is the member's IgE level ≥ 30 and ≤ 700 IU/ml? **Yes** **No** Please provider IgE level: _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature: _____ **Date of request:** _____





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Prescriber Signature: _____ **Date of request:** _____

