

## ~ XOLAIR ~

### Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Xolair. In order for beneficiaries to receive Medicaid coverage for Xolair, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to Catamaran. Please complete this form as directed and sign and date below. Incomplete requests will be returned for additional information.

**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:  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

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

**List all previous therapies tried and failed for this condition:**

Therapy	Specific Drug	Reason for 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  $\geq 30$  and  $\leq 700$  IU/ml?  Yes  No Please provide IgE level: \_\_\_\_\_

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