

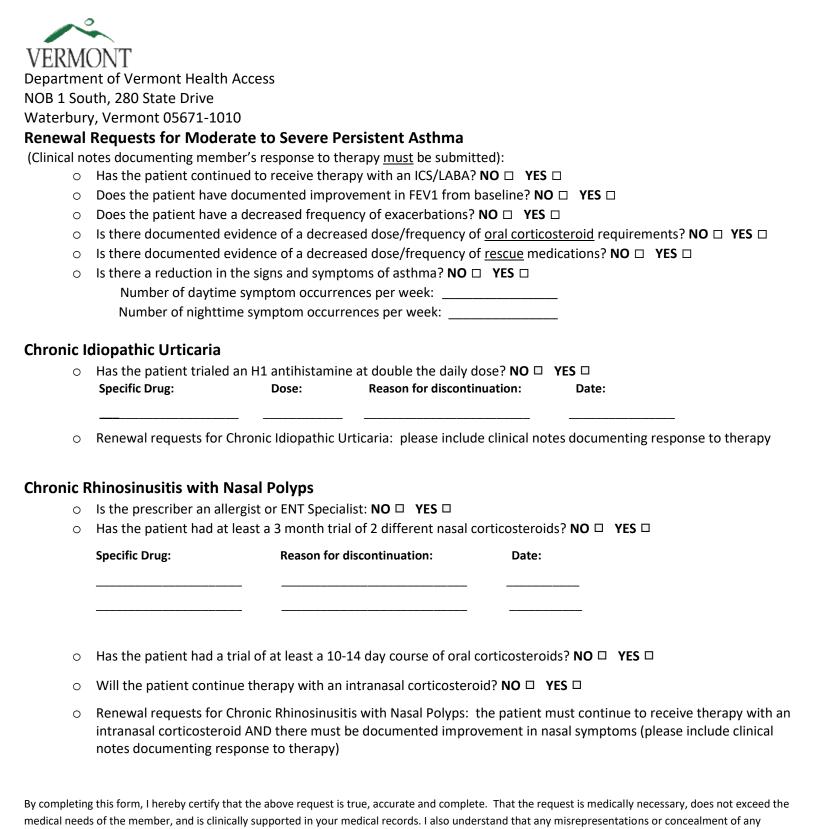
## ~Xolair~

## **Prior Authorization Request Form**

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must fax this form to Change Healthcare. Please complete this form in its entirety, and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare Helpdesk at 1-844-679-5363.

	Subm	it request via Fax: 1-8	44-679-5366	
rescr	ibing physician:	Beneficiary:		
Name:		Name:	Name:	
		Medicald ID#.	Medicald ID#.	
		Date of biftif	Sex	
		Patient's Phone: _		
		Pharmacy Name:	Pharmacy Name:	
		Pharmacy NPI:	Pharmacy Fax:	
		Pharmacy Phone:	Pharmacy Fax:	
	llowing MUST be completed for MED  J-code or other code:	ICAL BENEFIT requests:		
		NPI#	Medicaid ID#	
Dose:	Frequency:		Patient weight (kg):	
	lation: □ vial □ prefilled syringe			
Mode o	erate to Severe Persistent Asthma Is the member currently smoking? No lis the prescriber an allergist, immuno ICS/LABA combination product triale	O □ YES □ Quit Date (if appole of the contract of the contrac	□ YES □	
	Specific Drug: Res	sponse to therapy:	Dates of use:	
0	Does the patient have uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthmat least one a week): NO   Number of daytime symptom occurrences per week:  Number of nighttime symptom occurrences per week:			
0	Has the patient had 2 or more exacerbations in the previous year despite use of medium-high dose ICS/LABA? NO $\Box$ YES $\Box$			
0	Positive test to perennial aeroallergen by a skin or blood test: <b>NO YES Aeroallergen:</b>			
0	IgE level ≥ 30 and ≤ 700 IU/ml (ages	12 and older) or ≥ 30 and ≤ 13	00 (ages 6 to 11) prior to beginning therapy with	







Date:

information requested in the prior authorization request may subject me to audit and recoupment.

Prescribers Signature: