Shared Plans and Legacy Medicaid

Prior Authorization Requirement for Omalizumab (Xolair®)

Effective October 15, 2013, pharmacy claims billed for omalizumab (Xolair®) will require prior authorization (PA). Pharmacy claims without a PA will deny with:

NCPDP rejection code 75 (DUR Reject Error) mapped to

EOB code 485 (PA Required)

Prior authorization may be requested through the Louisiana Medicaid RxPA Operations at the University of Louisiana at Monroe College of Pharmacy. The omalizumab (Xolair ®) prior authorization form is available at www.lamedicaid.com following the link for pharmacy and prescribing providers. The form must be completed in full and signed by the prescribing practitioner. Signature stamps and proxy signatures are not acceptable. The completed form must be faxed from the prescribing practitioner to the Louisiana Medicaid RxPA Operations at the University of Louisiana at Monroe College of Pharmacy at 1-866-797-2329. Please refer to www.lamedicaid.com for complete PA instructions.

Medical reconsideration of a prior authorization decision may be requested by the prescribing practitioner. To request reconsideration, the *Request for Reconsideration* form must be completed in full and signed by the prescribing practitioner. Signature stamps and proxy signatures are not acceptable. The completed form must be faxed from the prescribing practitioner to the Louisiana Medicaid RxPA Operations at the University of Louisiana at Monroe College of Pharmacy at 1-318-812-2940.

FAX OR MAIL this form to:
La Medicaid Rx PA Operations
ULM College of Pharmacy
1800 Bienville Drive
Monroe, LA 71201-3765
FAX 866-RX PAFAX
FAX 866-797-2329

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR XOLAIR (OMALIZUMAB) PRIOR AUTHORIZATION

Form: Rx PA06
Issue Date: 3/01/2013
Voice Phone: 866-730-4357

Please type or print legibly. Incomplete forms will not be approved.

Date of Request	Number of Fax Pages
Prescribing Provider Information	**Recipient Information**
Name (Last, First)	Name (Last, First)
LA Medicaid Prescribing Provider Number / NPI	LA Medicaid CCN or Recipient Number
Provider Specialty	Date of Birth (mm/dd/yy)
Call-Back Phone Number (include area code)	Recipient Weight (kg)
FAX Number (Include area code)	Recipient Height (ft / in)
Office Contact Name	Medication Allergies

Requested Drug Information			
Initiation of Therapy ☐ Continuation of Therapy ☐		Projected Duration of Treatment	
Drug Name	Drug Strength	Dosage Form	Dosage Interval (sig)
Diagnosis Code (ICD -9-CM) Relevant for this Request		Diagnosis Description	Quantity

Please answer the following questions for your request to prescribe this medication for your patient:

1. Xolair dosage will be _____mg SQ every: (choose one) ☐ 2 WEEKS ☐ 4 WEEKS

2. Indication criteria: (Must meet all of the following for consideration)

☐ Diagnosis of Moderate to Severe Persistent Asthma

☐ Age > or = to 12 years old

☐ Elevated IgE level:_____

☐ Inadequate response to medium to high dose inhaled corticosteroids PLUS inhaled long acting beta agonist OR leukotriene modifier: (list below)
Drug_____Dosage_____Duration of therapy_____

Drug_____Dosage_____Duration of therapy_____

Practitioner Signature: _____
(If a signature stamp is used, then the prescribing practitioner must initial the signature.)