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:

State of Louisiana

Department of Health and Hospitals

La Medicaid Rx PA Operations ULM College of Pharmacy Bureau of Health Services Financing

1800 Bienville Drive

Louisiana Medicaid Prescription Prior Authorization Program

Monroe, LA 71201-3765 FAX 866-RX PAFAX FAX 866-797-2329

REQUEST FOR XOLAIR (OMALIZUMAB) PRIOR AUTHORIZATION

Voice Phone: 866-730-4357

Form: Rx PA06

Issue Date: 3/01/2013

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

rease type or prim regioty.	meompiete jorms witt no	i de approvea.		
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 D	Orug 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 bemg 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				
Elevated IgE level:				
Inadequate response to medium to high dose inhaled corticosteroids PLUS inhaled long acting beta agonist OR leukotriene modifier: (list below)				
Drug	DrugDosage		Duration of therapy	
Drug	DrugDosage		Duration of therapy	
Practitioner Signature:	fa signatura stamp is used	then the prescribing practitioner m	and finite laborate	
(i)	, a signature stamp is usea, t	nen me prescribing practitioner m	usi inilial the signature.)	

CONFIDENTIAL NOTICE

The documents accompanying this facsimile transmission may contain confidential information which is legally privileged. The information is intended only for the use of the individual or entity to which it is addressed. If you are not the intended recipient you are hereby notified that any review, disclosure/re-disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy this information.