FAX OR MAIL this form to:
La Medicaid Rx PA Operations
ULM School 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
Revised Date: 2/12/2015
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)	Recipient Height (ft / in)
FAX Number (Include area code)	Medication Allergies	
Office Contact Name	EPSDT Support Coordinator (Name / Address) *(optional)*	

Requested Drug Information

Initiation of Therapy ☐ Continuation of Therapy ☐

Drug Name	Drug Strength	Dosage Form	Dosage Interval (sig)

Diagnosis Code [Relevant for this Request]	Diagnosis Description	Quantity

Please answer the questions below for the corresponding indication.

ALLERGIC ASTHMA	**CHRONIC IDIOPATHIC URTICARIA**
Xolair dosage will be _____mg SQ every: ☐ 2 weeks ☐ 4 weeks Indication criteria: (*Must meet all of the following for consideration)* ☐ Diagnosis of Moderate to Severe Persistent Allergic Asthma ☐ Age > or = to 12 years old ☐ Elevated IgE level:_____Date drawn_____ ☐ Inadequate response to medium to high dose inhaled corticosteroids PLUS inhaled long acting beta agonist OR leukotriene modifier *MUST LIST BELOW*	Xolair dosage will be _____mg SQ every: ☐ 2 weeks ☐ 4 weeks Indication criteria: (*Must meet all of the following for consideration)* ☐ Diagnosis of Chronic Idiopathic Urticaria ☐ Age > or = to 12 years old ☐ Symptomatic despite H1 antihistamine treatment (Minimum of 4 weeks) *MUST LIST BELOW*

Drug_____Dosage_____Duration of Therapy_____
Drug_____Dosage_____Duration of Therapy_____
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.)