

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) <i>(optional)</i>	
Requested Drug Information			
Initiation of Therapy <input type="checkbox"/>		Continuation of Therapy <input type="checkbox"/>	
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: <input type="checkbox"/> 2 weeks <input type="checkbox"/> 4 weeks Indication criteria: <i>(Must meet all of the following for consideration)</i> <input type="checkbox"/> Diagnosis of Moderate to Severe Persistent Allergic Asthma <input type="checkbox"/> Age > or = to 12 years old <input type="checkbox"/> Elevated IgE level: _____ Date drawn _____ <input type="checkbox"/> 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: <input type="checkbox"/> 2 weeks <input type="checkbox"/> 4 weeks Indication criteria: <i>(Must meet all of the following for consideration)</i> <input type="checkbox"/> Diagnosis of Chronic Idiopathic Urticaria <input type="checkbox"/> Age > or = to 12 years old <input type="checkbox"/> 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.)

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