VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ XOLAIR ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Xolair. In order for beneficiaries to receive Medicaid coverage for Xolair, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form as directed and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing Physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Specialty: _____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Patient Diagnosis:☐Moderate/Severe Persistent Asthma

☐Other: _____

If requesting prescriber is not a pulmonologist, allergist, or immunologist, date of last visit to one (required yearly):

Specialist name: _____ **Specialist Type**: _____ **Date:** _____

☐ **Initial Prior Authorization Request:** Please complete all portions of form below

☐ **Subsequent PA Request:** Has patient shown marked clinical improvement ☐ **Yes** ☐ **No**

List all previous therapies tried and failed for this condition:

Therapy	Specific Drug	Reason for Discontinuation
Inhaled Corticosteroid		
Chronic Oral Corticosteroid		
Leukotriene Receptor Antagonist		
Long-Acting Beta Agonist		

Has the member tested positive to at least one perennial aeroallergen by a skin or blood test (i.e. RAST, CAP, intracutaneous test)? ☐**Yes** ☐**No**
Please explain: _____

Is the member's IgE level ≥ 30 and ≤ 700 IU/ml? ☐**Yes** ☐ **No** Please provide IgE level: _____

Prescriber Signature:_____ **Date of this request:**_____

Last Updated: 04/2011