



Xolair® (Omalizumab)
 New Hampshire Medicaid Prior Authorization
 Request Form



Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ____/____/____

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____	NH Medicaid Number: _____
Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

Section II: Clinical History:

1. Is the patient's age 13 years of age or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the patient have a diagnosis of moderate to severe persistent asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the patient symptomatic despite taking medium to high dose inhaled corticosteroids or oral steroids in combination with either a long-acting beta ₂ agonist or a leukotriene modifier, or theophylline?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the patient's allergy been confirmed by skin testing or invitro activity to the allergen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is the patient's IgE result > 30IU/mL and ≤ 700 IU/ml? _____ IU/ml	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the patient poorly compliant on current asthma treatment plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Is a pulmonologist, allergist, or immunologist prescribing this medication, or has one of these specialists been consulted in this case?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is the patient an active smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is this patient being treated exclusively for peanut allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page _____ _____ _____	

Section III: Prescriber Information:

Name: _____	NPI Number: _____
Phone Number: (____) _____ - _____	Fax Number: (____) _____ - _____
<p>I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.</p>	
<p>_____ Signature of Prescribing Provider</p>	