

XOLAIR PA FORM



Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Xolair must meet the following criteria:

- **Patient must have moderate to severe persistent asthma**
- **Patient must have serum IgE level between 30 and 700 IU/mL**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Physician Name		Specialist Involved in Therapy (if not treating physician)			
Physician Medicaid Provider Number		Telephone Number		Fax Number	
Address		City		State	Zip Code
Requested Drug and Dosage: <input type="checkbox"/> XOLAIR		Diagnosis for this Request:		Serum IgE Level:	
Physician Signature				Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	