XOLAIR® Prior Authorization Form
(omalizumab)

West Virginia Medicaid
Drug Prior Authorization Form
http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last)	(First)	(MI)	WV Medicaid 11-Digit ID #	Date of Birth (MM/DD/YYYY)

Prescriber Name (Last)	(First)	(MI)

Prescriber Address (Street)	(City)	(State)	(Zip)
		WV	

Prescriber 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street)	(City)	(State)	(Zip)
		WV	

Pharmacy 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)

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Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

	Strength	Route of Administration
XOLAIR®	150 mg	Sub-Q Injection
Directions	Diagnosis	ICD Diagnosis Code (if available)

1. Does the patient have a diagnosis of moderate to severe persistent allergic asthma? ☐ Yes ☐ No (not approved)

2. Is the patient 12 years of age or older? ☐ Yes ☐ No (not approved)

3. Is the patient's current weight between 30kg and 150kg? ☐ Yes ☐ No (not approved) Weight in kg:

4. Is the patient symptomatic despite receiving other recommended first-line treatments? ☐ Yes (List previously failed treatments and other concurrent medications. See criteria for requirements.) ☐ No (not approved)

5. Has the patient been compliant with other recommended first-line treatments? ☐ Yes ☐ No (explain)

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6. Has the patient reacted positively to a perennial aeroallergen skin or blood test?	☐ Yes ☐ No (not approved)	Date of test:
7. Baseline IgE level:		Date of test:
8. I am a board certified pulmonologist or a board certified allergist.	☐ Yes ☐ No (go to 9)	
9. Treatment was recommended for this patient by a board certified pulmonologist or a board certified allergist. (name/address)		

Other Pertinent Information **(attach additional pages)**

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.	☐ Check here for electronic signature
Prescriber or Pharmacist Signature:	Date: (MM/DD/YYYY)