



PA12 - XOLAIR
NOT required for recipients less than 21 years of age.

Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
DXC Technology · 301 Metro Center Blvd., 3rd Floor · Warwick, RI 02886
FAX 401-784-3889 ATTN : PHARMACIST

CLIENT NAME: _____ DOB: ____ / ____ / ____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER () _____ FAX NUMBER () _____

DRUG REQUESTED: _____ QTY / FILL _____

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD 10 CODE.

___ DOES THE PATIENT HAVE A DIAGNOSIS OF ASTHMA? ICD10 CODE _____

___ IS THE PRESCRIBER A PULMONOLOGIST, ALLERGIST OR IMMUNOLOGIST? (Y/N)

___ IS THERE EVIDENCE OF AN AEROALLERGEN PRESENT? (Y/N)

___ IS THE IGE LEVEL GREATER THAN 30 IU/ML? (Y/N)

___ IS THE PATIENT INADEQUATELY CONTROLLED ON ORAL/INHALED MEDICATIONS? (Y/N)

IF YES, PLEASE INDICATE CURRENT AND PAST DRUG REGIMENS:

COMMENTS: _____

PRESCRIBER SIGNATURE _____ DATE _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

CONTACT DXC TECHNOLOGY CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: ____ YES ____ NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____ TO _____