STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:

1-866-409-8386 FAX: 1-866-759-4110

(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

CT Medical Assistance Program Prior Authorization (PA) Request Form

XOLAIR (omalizumab)

Prescriber Information	Patient Information
Prescriber's Name (Last, First):	Member's Name (Last, First):
Prescriber's NPI:	Member's ID:
Prescriber's Phone:	Patient's Date of Birth (MMDDCCYY):
Prescriber's Fax:	
Prescription Information	
Drug Requested:	Quantity Requested:

Clinical Information

Moderate-to-Severe Persistent Asthma (Patients 6+ years): • Is the patient 6 years or older, diagnosed with moderate-to-severe persistent asthma, positive for skin test or in vitro reactivity to a perennial aeroallergen, and experiencing symptoms not adequately controlled with inhaled corticosteroids?	☐ **Yes** ☐ **No**
Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (Patients 18+ years): • Is the patient 18 years or older, diagnosed with chronic rhinosinusitis with nasal polyps, and experiencing inadequate response to nasal corticosteroids, requiring an additional maintenance treatment?	☐ **Yes** ☐ **No**
IgE-Mediated Food Allergy (Patients 1+ years): • Is the patient 1 year or older, diagnosed with an IgE-mediated food allergy (Type I), and in need of reducing allergic reactions, including anaphylaxis, due to accidental food exposure, while also planning to use food allergen avoidance?	☐ **Yes** ☐ **No**
Chronic Spontaneous Urticaria (Patients 12+ years): • Is the patient 12 years or older, diagnosed with chronic spontaneous urticaria, and still symptomatic despite H1 antihistamine treatment?	☐ **Yes** ☐ **No**

If you answered "No" to the question for the specific indication above, based on the client age or diagnosis, regarding the medication requested, please provide other information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient. Submit request, via email, to rx.lmn@ct.gov.

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the

Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. Authorizations for Early Refill Requests are valid one time only.

Signature of Prescriber* _____ **Date (MM/DD/CCYY)** _____

Mandatory (others may not sign for prescriber). **In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**