Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

Xolair® (Omalizumab)
Prior Authorization Renewal Request Form

Beneficiary Information

Name: _____

Medicaid ID #: _____ Date of Birth: _____

Billing Provider Information (Pharmacy, Physician, or Facility)

Name: _____ Medicaid ID #: _____

NPI #: _____ Phone #: _____ Fax #: _____

Requested Drug: _____ NDC: _____

Requested Procedure Code (if applicable): _____ Total # of Units Requested (per 6 months): _____

Prescriber Information

Name: _____ Medicaid ID #: _____

NPI #: _____ Phone #: _____ Fax #: _____

Requested Information

1. Document Date/Dose of injections for past 6 months:

   Date: _____ Dose: _____ Date: _____ Dose: _____

   Date: _____ Dose: _____ Date: _____ Dose: _____

   Date: _____ Dose: _____ Date: _____ Dose: _____

   Date: _____ Dose: _____ Date: _____ Dose: _____

   Date: _____ Dose: _____ Date: _____ Dose: _____

   Date: _____ Dose: _____ Date: _____ Dose: _____

   Dosage: _____

2. Provide most recent FEV1 or PEF testing:

   Date of testing: _____ FEV1%: _____ PEF %: _____

   Document % improvement in lung function test:_____

3. Has patient had a documented decrease in the number of asthma exacerbations? ☐ Yes ☐ No
4. Has patient had a symptomatic improvement per physician assessment? ☐ Yes ☐ No

Prescriber's Signature: _____ Date: _____

The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.

Prior Authorization Phone #
1-800-285-4978 or 785-274-5499

Revised September 2014