CSHCN Services Program Authorization Request for Omalizumab

Complete the following form and submit to the TMHP-CSHCN Services Program Authorization Department at 12357-B Riata Trace Parkway, Suite 150, MC-A11, Austin TX 78727 or fax to 1-512-514-4222.

For help completing this form, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 or 1-512-514-3000 and select Option 2.

Please print or type requested information below.

Client Information

First name:	Last name:
CSHCN Services Program number: 9-__________________________-00	Date of birth: *(Client must be 12 years of age or older)*
Address/City/ZIP:	
Diagnosis (ICD-9-CM):	

Statement of Medical Necessity

Indicate dose and frequency of administration for Omalizumab:		
Request period:	☐ Initial 3 months	☐ Additional 3 months *(document compliance & efficacy in narrative)*
Documentation includes:	☐ Positive skin test and date:__________________**or**	☐ RAST test and date: ______________
and ☐ Total IgE level:______________________________ and date: __________________________		
and ☐ Requires 660 mcg or more of inhaled steroid treatment		
and ☐ Client is compliant with asthma treatment		
and ☐ Client has:	☐ Significantly declining PFT's **or** ☐ Client has dependence on continuous systemic steroids **or**	☐ Frequent hospitalizations for exacerbations **or** ☐ Maximal inhaled steroid regimen with frequent systemic steroid pulses
and ☐ Client has:	☐ Been on daily therapy for persistent asthma 12 months with daily use of a beta agonist **or**	☐ FEV 1.0 is < 80% predicted with a FEV 1.0/FVC ratio < 0.7
and ☐ Client has:	☐ A 12% or greater post-bronchodilator improvement of FEV 1.0 **or**	☐ Document in narrative why client is unable to perform PFT's
Is client currently pregnant or breastfeeding? ☐ Yes ☐ No	Does client currently smoke? ☐ Yes ☐ No	
Narrative:		
I certify that the patient's medical condition is such that the medication requested is medically necessary.		
Type or print physician's name:	Telephone:	
Physician's signature:	Date signed:	

Provider Information

Provider name:	Contact person:
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/ZIP:	
Provider signature:	Date: