Xolair® (omalizumab) Self-Administration Physician Attestation

I, _____ , (Prescriber's full name & title)

as treating healthcare provider for

_____ (Patient's full name, including middle initial)

_____, (Patient's DOB)

am requesting Xolair® (omalizumab) be dispensed by Accredo to the patient's home for subcutaneous administration.

I affirm:

The patient received at least 3 doses of Xolair under the guidance of a healthcare provider without hypersensitivity reactions and the healthcare provider has completed the assessment of risk for anaphylaxis and mitigation strategies, and has determined that self-administration is appropriate.

_____

Printed Prescriber's Full Name (First and Last)

_____ _____

Signature Date

***Please complete Xolair Referral form at xolair.pdf (accredo.com) if a prescription for an Epi-Pen® is needed.

Fax to Accredo at 888.286.8954