Please fax all pages of completed form to your team at 866.531.1025.
To reach your team, call toll-free 866.839.2162.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Xolair® (omalizumab)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

ICD-10 code (REQUIRED): _____

☐ NKDA ☐ Known drug allergies _____

Prior anaphylactic reaction: ☐ No ☐ Yes (Reason/date _____)

Concurrent meds _____

Concomitant therapies: ☐ Short-acting beta agonist ☐ Long-acting beta agonist ☐ Antihistamines ☐ Decongestants ☐ Immunotherapy

☐ Inhaled corticosteroid ☐ Leukotriene modifiers ☐ Oral steroids ☐ Nasal steroids ☐ Other _____

Lab results: ☐ History of positive skin OR RAST test to a perennial aeroallergen

Pre-treatment serum IgE level _____ IU per mL Test date _____ Pre-treatment serum eosinophils _____ cells/mcL

and/or sputum eosinophils _____ Date _____ Patient wt _____ kg Date wt obtained _____

MD Specialty (required): ☐ Allergist ☐ Pulmonologist ☐ ENT ☐ Primary care ☐ Pediatrician ☐ Other _____

Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continued therapy

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Xolair® (omalizumab)	☐ Autoinjector *Pharmacy to dispense the least amount of autoinjectors to complete total dose. Autoinjectors available in 75mg, 150mg, and 300mg.* ☐ Prefilled syringe *Pharmacy to dispense the least amount of syringes to complete total dose. Prefilled syringe available in 75mg, 150mg, and 300mg.* ☐ 150mg single dose vial	**Every 4 weeks dosing:** ☐ Inject 75mg per dose under the skin every 4 weeks ☐ Inject 150mg per dose under the skin every 4 weeks ☐ Inject 225mg per dose under the skin every 4 weeks ☐ Inject 300mg per dose under the skin every 4 weeks ☐ Inject 450mg per dose under the skin every 4 weeks ☐ Inject 600mg per dose under the skin every 4 weeks ☐ Inject other: _____ mg per dose under the skin every 4 weeks **Every 2 weeks dosing:** ☐ Inject 225mg per dose under the skin every 2 weeks ☐ Inject 300mg per dose under the skin every 2 weeks ☐ Inject 375mg per dose under the skin every 2 weeks ☐ Inject 450mg per dose under the skin every 2 weeks ☐ Inject 525mg per dose under the skin every 2 weeks ☐ Inject 600mg per dose under the skin every 2 weeks ☐ Inject other: _____ mg per dose under the skin every 2 weeks	☐ 1-month supply ☐ 3-month supply ☐ Other: _____ Refills _____
☐ Epinephrine/EpiPen®	☐ 0.3mg IM as needed for anaphylaxis ☐ 0.15mg IM as needed for anaphylaxis		1-month supply Refill x 1 year unless noted otherwise ☐ Other: _____
☐ Other			
Xolair vial supplies: Sterile water for injection 10mL vial for reconstitution QS per doses Administration Supply Kit consisting of: • Alcohol swabs • Flexible bandages 1" x 3" • 3mL Luer Lock injection syringe • NDL 18G x 1 1/2" Safety Glide needle for reconstitution • NDL 25G x 5/8" Safety Glide needle for subcutaneous injection ☐ No supplies (Supplies will be sent with shipment unless indicated.)			Send quantity sufficient for medication days supply

Xolair Self-Administration Physician authorization to ship to the home

Has the patient received at least 3 doses of Xolair under the guidance of a healthcare provider without hypersensitivity reactions and the health-care provider has completed the assessment of risk for anaphylaxis and mitigation strategies, and has determined that self-administration is appropriate? ☐ Yes ☐ No

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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