Prescription & Enrollment Form

Xolair® (omalizumab)

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's name _____

Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____

Cell phone _____ Evening phone _____

E-mail address _____

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

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____

Phone _____

Insured's name _____

Insured's employer _____

Relationship to patient _____

Identification # _____

Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____

Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's name and title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Clinic

Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____

❑ NKDA ❑ Known drug allergies _____

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

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

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
Xolair® (omalizumab) ❑ Asthma *(dose is dependent on weight and IgE levels, see package insert)* ❑ CIU *(fixed dose, not dependent on weight or IgE)*	❑ Prefilled syringe *Pharmacy to dispense the least amount of syringes to complete total dose. Prefilled syringe available in 75 mg and 150 mg.* ❑ 150 mg single dose vial	**Every 4 weeks dosing:** ❑ Administer 75 mg per dose subcutaneously every 4 weeks ❑ Administer 150 mg per dose subcutaneously every 4 weeks ❑ Administer 300 mg per dose subcutaneously every 4 weeks ❑ Administer other: _____ mg per dose subcutaneously every 4 weeks **Every 2 weeks dosing:** ❑ Administer 225 mg per dose subcutaneously every 2 weeks ❑ Administer 300 mg per dose subcutaneously every 2 weeks ❑ Administer 375 mg per dose subcutaneously every 2 weeks ❑ Administer other: _____ mg per dose subcutaneously every 2 weeks	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Xolair vial supplies: Sterile water for injection 10 mL vial for reconstitution QS per doses Administration Supply Kit consisting of: • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL 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

Physician accepts on behalf of patient for administration in office or clinic.

By signing below, I certify that the above therapy is medically necessary.

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

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

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.

Please fax completed form to your team at 866.531.1025.

To reach your team, call toll-free 866.839.2162.

You can now track shipments for all your Accredo patients.

Go to https://prescribers.accredo.com and click "Help" to register.

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