accredo® Specialty Pharmacy

Xolair® Shipment Request

Please complete the form and send with the specific patient information.

Xolair fax: 866.531.1025 Xolair phone: 866.839.2162

Next Xolair scheduled injection date _____

Date order requested to be delivered by (Tuesday–Friday) _____

Special delivery instructions _____

(If requested delivery date is less than 5 days from now, please call the pharmacy directly at **866.839.2162**.)

Is the delivery address same as above: ❑ YES ❑ NO

If address is different, please contact the pharmacy to schedule at **866.839.2162**.

Office representative completing the form _____

Patient/Guardian/Caregiver authorization to ship: ❑ YES ❑ NO

Patient/Guardian/Caregiver signature authorizing to ship

_____

Changes in insurance? ❑ YES ❑ NO

If YES, patient must contact the pharmacy at **866.839.2162**.

Changes for the next patient Xolair dose or other prescription changes? ❑ YES ❑ NO

If YES, please fax a new Rx to **866.531.1025** and pharmacy will contact the office to set up shipment when processing is complete.**

If you would like to discontinue shipments for this patient, please contact the pharmacy at **866.839.2162**.

Please provide the below patient information (please print):

Patient name	
Date of birth	
Rx number (optional)	

If you are sending a new prescription, please fax to: **866.531.1025.

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