

**1 PATIENT INFORMATION**

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 \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Insurance Company Phone No. \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Identification No. \_\_\_\_\_ Policy/Group No. \_\_\_\_\_  
Prescription Card  No  Yes If Yes, Carrier \_\_\_\_\_  
Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Is patient eligible for Medicare?  No  Yes **Please attach front and back copy of patient's insurance cards, if available.**

**2 PRESCRIBER INFORMATION**

Prescriber's Name \_\_\_\_\_  
Office Contact \_\_\_\_\_  
Clinic / Hospital Affiliation \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
E-mail address \_\_\_\_\_  
NPI No. \_\_\_\_\_ License No. \_\_\_\_\_  
DEA No. \_\_\_\_\_  
Physician Medicaid UPIN No. \_\_\_\_\_  
**MD Specialty (required)**  Allergist  Pulmonologist  ENT  Primary Care  
 Pediatrician  Other \_\_\_\_\_

**3 CLINICAL INFORMATION**

**Primary ICD-9 Code:** 493. \_\_\_\_ \_\_\_\_ (Please complete code to indicate status of asthmaticus condition)  
**Secondary ICD-9 Code:** \_\_\_\_\_  
**Concomitant Therapies:**  
 Short Acting Beta Agonist  Inhaled Corticosteroid  Oral Steroids  
 Long Acting Beta Agonist  Leukotriene Modifiers  Immunotherapy  
 Antihistamines/Decongestants  Nasal Steroids  
Other \_\_\_\_\_  
**Clinical Impression:** \_\_\_\_\_  
\_\_\_\_\_  
**Lab Results:**  History of positive skin **OR** RAST test to a perennial aeroallergen  
**Pretreatment serum IgE level:** \_\_\_\_\_ IU per mL Test Date \_\_\_\_\_  
Patient wt \_\_\_\_\_ kg Date wt obtained \_\_\_\_\_  
 NKDA  Known Drug Allergies: \_\_\_\_\_

**4 PRESCRIBING INFORMATION**

**Rx:** Dispense Xolair  
**Dosage (choose one):**  150  300 mg subcutaneously, every 4 weeks **OR**  
 225  300  375 mg subcutaneously, every 2 weeks  
**Dispense:**  1  2  3  6 months supply Refill \_\_\_\_\_ times.  
Prescription to include ancillary supplies and diluent as needed for injections.  
**Deliver product to:**  Office  Other \_\_\_\_\_  
If shipped to physician's office, physician accepts on behalf of patient for administration in office.  
*By signing below, I certify that the rationale for Xolair therapy for Allergic Asthma is necessary for this patient, and I will be supervising the patient's treatment accordingly.*  
**Prescriber's Printed Name** \_\_\_\_\_  
**Prescriber's Signature (sign one)** \_\_\_\_\_ **Date** \_\_\_\_\_

Dispense as Written

Substitution Allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)

To reach your team, call toll-free 1 866 839-2162.

**Please fax completed form to the Xolair team 1 866 531-1025**