677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Prescription & Enrollment Form

Xolair® (omalizumab)

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name ______________________________
Last name ______________________ Middle initial _____
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 copies of 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 first name ______________ Last name ______________
Prescriber's title ______________________________
If NP or PA, under direction of Dr. ______________________
Office contact and title ______________________
Office contact e-mail ______________________
Office/clinic/institution name ______________________
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 75mg and 150mg.* ❑ 150mg single dose vial	**Every 4 weeks dosing:** ❑ Administer 75mg per dose subcutaneously every 4 weeks ❑ Administer 150mg per dose subcutaneously every 4 weeks ❑ Administer 300mg per dose subcutaneously every 4 weeks ❑ Administer other: ________ mg per dose subcutaneously every 4 weeks **Every 2 weeks dosing:** ❑ Administer 225mg per dose subcutaneously every 2 weeks ❑ Administer 300mg per dose subcutaneously every 2 weeks ❑ Administer 375mg 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 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

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

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. **Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)**

PHYSICIAN SIGNATURE REQUIRED

__________ ______________________ __________ ______________________
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.

Please fax completed form to your team at 808.650.6487. To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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AST-00001-H-120820 amc9631 CRP1904_ A0164