Please fax both 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 attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

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

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

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

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

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

❑ OK to leave message with alternate caregiver/contact

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 ❑ Patient's home ❑ Clinic Clinic location _____

3 Clinical Information

ICD-10 code required: _____

❑ 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

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) ❑ Asthma *(dose is dependent on weight and IgE levels, see package insert)* ❑ CIU *(fixed dose, not dependent on weight or IgE)* ❑ Nasal Polyposis	❑ 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 225mg per dose subcutaneously every 4 weeks ❑ Administer 300mg per dose subcutaneously every 4 weeks ❑ Administer 450mg per dose subcutaneously every 4 weeks ❑ Administer 600mg 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 450mg per dose subcutaneously every 2 weeks ❑ Administer 525mg per dose subcutaneously every 2 weeks ❑ Administer 600mg per dose subcutaneously every 2 weeks ❑ Administer other: _____ mg per dose subcutaneously every 2 weeks	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other: _____ Refills _____
❑ Epinephrine/EpiPen®	❑ 0.3mg IM as needed for anaphylaxis ❑ 0.15mg IM as needed for anaphylaxis		Dispense: 1-month supply Refill x 1 year unless noted otherwise ❑ 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® (Omalizumab) Self-Administration Physician Attestation

I, _____ (PRESCRIBER'S FULL NAME AND TITLE), as treating physician for _____ (PATIENT FULL NAME INCLUDING MIDDLE INITIAL AND DATE OF BIRTH) am requesting Xolair® (Omalizumab) be dispensed by Accredo to the patient's home for subcutaneous administration.

I affirm:

❑ Patient has no prior history of anaphylaxis, including to XOLAIR or other agents, such as foods, drugs, biologics, etc.
❑ Patient has received at least 3 doses of XOLAIR under the guidance of a healthcare provider with no hypersensitivity reactions
❑ Patient or caregiver is able to recognize symptoms of anaphylaxis
❑ Patient or caregiver is able to treat anaphylaxis appropriately
❑ Patient or caregiver is able to perform subcutaneous injections with XOLAIR prefilled syringe with proper technique according to the prescribed dosing regimen and Instructions for Use

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

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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