

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male  Female  
 Home Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Parent/Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Shipping Address:  Home  Physician  Other \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Allergies:  NKA \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information** (Fill out completely OR fax a copy of patient's insurance card – both sides)  
 Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Rx Drug Card #: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Rx Drug Card #: \_\_\_\_\_

**Prescriber Information**  
 Prescriber Name: \_\_\_\_\_ Hospital/Clinic: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 NPI #: \_\_\_\_\_ License #: \_\_\_\_\_  
 Specialty:  Allergist  Pulmonologist  Other \_\_\_\_\_

**Medical Necessity Assessment/ICD-9 Code**  
 Primary  Secondary  493. \_\_\_\_\_ (Please complete digits(s) to indicate status asthmaticus condition)  
 Other \_\_\_\_\_

**Concomitant Therapies** (Check all that apply)  
 Short Acting Beta Agonist  Inhaled Corticosteroid  Oral Steroids  Combination therapy (LAB/ICS)  
 Long Acting Beta Agonist  Leukotriene Modifier  Immunotherapy  Other (specify) \_\_\_\_\_

**Lab Results**  History of positive skin or RAST test to a perennial aeroallergen  
 Pretreatment Serum IgE level \_\_\_\_\_ IU/mL Test Date \_\_\_\_\_  
 Pt Weight \_\_\_\_ (kg) or \_\_\_\_ (lbs)  
 Date \_\_\_\_\_

**Clinical Impression**  
 \_\_\_\_\_  
 \_\_\_\_\_

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.

**TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL OR COMPLETE THE FOLLOWING:**

**Prescription Type:**  New  Continuing Therapy  Restart  Drug Allergies \_\_\_\_\_  NKA  
 Please Dispense: **Xolair**® (Omalizumab) for Subcutaneous Use, 150mg vial  
 Reconstitute **Xolair**® vial with 1.4mL of Sterile Water for Injection and give:  
 150mg/1.2mL  300mg/2.4mL  
 225mg/1.8mL  375mg/3.0mL  
 subcutaneous every \_\_\_\_\_ weeks  
 Dispense  Diluent: 10-cc vial preservative-free sterile water for injection  
 Supplies, syringes and needles for preparation and administration of Xolair®  
 Dispense: One (1) month supply Refill \_\_\_\_\_ times  Home Nursing Visit for Self-Injection Training  
 Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Dispense as Written  Generic Substitution Permitted