Genentech | ACCESS SOLUTIONS
A Member of the Roche Group

for XOLAIR®
(omalizumab) FOR SUBCUTANEOUS USE

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **XOL/021219/0023** **02/19**

Step 1 Patient Information

***First name:** _____ ***Last name:** _____

***Date of birth (MM/DD/YYYY):** ____/____/____ Gender: ☐Male ☐Female

Street: _____ Apt: _____

City: _____ ***State:** _____ ZIP: _____

Home phone: (____) ____-____ Cell phone: (____) ____-____ ☐Do not contact patient

Email: _____ Preferred language: ☐English ☐Spanish ☐Other: _____

Alternate contact name: _____ Relationship: _____ Alt. phone: (____) ____-____

Step 2 Insurance Information

Is the patient insured? ☐Yes ☐No Has patient started therapy? ☐Yes ☐No

If patient is uninsured, please complete the Genentech Patient Foundation Enrollment Form or call (888) 941-3331 for assistance.
If insured, please fill out the information below or attach a copy of the patient's insurance cards.

	Primary Insurance	Secondary Insurance
Insurance name		
Subscriber name (if not patient)		
Subscriber/Policy ID		
Group #		
Insurance phone		

Step 3 Diagnosis and Clinical Information

***Complete to the highest level of specificity for diagnosis codes:**

ALLERGIC ASTHMA ☐J45.40 Moderate persistent asthma, uncomplicated ☐J45.50 Severe persistent asthma, uncomplicated

CHRONIC IDIOPATHIC URTICARIA ☐L50.1 Idiopathic urticaria ☐**Other diagnosis code:** _____

Step 4 Acquisition and Administration Information

Dispense: ☐Prefilled Syringe or ☐Vial Dispensing of XOLAIR through: ☐Specialty pharmacy (SP) ☐Buy and bill

Anticipated date of treatment: ____/____/____ Preferred specialty pharmacy: _____

Place of administration: ☐Physician's office ☐Hospital-based Outpatient Dept. (HOPD) ☐Alternate injection center

Ship to: ☐Physician's office ☐Hospital-based Outpatient Dept. (HOPD) ☐Alternate injection center

Place of administration name: _____ Place of administration tax ID #: _____

Street: _____ Suite: _____ City: _____ State: _____ ZIP: _____

Step 5 Prescriber Information

***First name:** _____ ***Last name:** _____

***Practice name:** _____

***Street:** _____ Suite: _____

***City:** _____ ***State:** _____ ***ZIP:** _____

Prescriber tax ID #: _____ Prescriber NPI† #: _____ Group NPI #: _____

Office contact: _____ Contact phone: (____) ____-____ Contact fax: (____) ____-____

Step 6 Health Care Provider Certification

By submitting this form, I certify: (a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician. (b) If the indication for which this Genentech product is being prescribed to treat is not listed in the FDA-approved label, the prescriber is prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication for such a use. (c) The provider's office received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome. (d) The provider's office will not attempt to seek reimbursement for free product provided to the patient. (e) The services requested on behalf of the patient may include benefits investigation (BI), prior authorization (PA) and appeals support, co-pay card and co-pay assistance foundation referral. **(f) No action on these services will be taken until the patient consent document has been received.**

†National Provider Identifier.

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Step 7 Patient Information (please re-enter)

***First name:** _____ ***Last name:** _____ ***Date of birth (MM/DD/YYYY):** ____/____/____

Step 8 XOLAIR Starter Program (signature required)

For eligibility criteria, please speak to your XOLAIR representative.

XOLAIR Starter Program prescription: ☐ Dispense a free 28-day XOLAIR starter supply refill x2 subcutaneously

ALLERGIC ASTHMA

☐ Moderate to severe persistent allergic asthma ☐ History of positive skin or RAST test to a perennial aeroallergen

☐ Symptoms inadequately controlled with ICS

Pretreatment serum IgE level IU/mL (1.0 kU/L=1.0 IU/mL; 2.4 ng/mL=1.0 IU/mL): IgE level: _____ Patient weight: _____ kg

CHRONIC IDIOPATHIC URTICARIA (CIU)

☐ Patient has had CIU for 6 weeks or more

Other CIU therapies: ☐ H1 antihistamine ☐ Other: _____

Step 9 Prescription Information

Prescription type: ☐ **Naïve/new start** ☐ **Restart** ☐ **Continued Tx** **Last injection date:** ____/____/____

Dispense: ☐ Prefilled Syringe ☐ Vial

☐ ALLERGIC ASTHMA ☐ CIU ☐ Other: _____

***Quantity dispensed:** ☐ 30-day supply ☐ 90-day supply Refill: _____ times

☐ Diluent: 10-mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringes as needed for reconstitution; 18-gauge needles as needed for reconstitution; 25-gauge needles as needed for administration.

Prescription:

SIG ☐ 75 mg/dose every 4 weeks SIG ☐ 150 mg/dose every 4 weeks SIG ☐ 225 mg/dose every 4 weeks

SIG ☐ 300 mg/dose every 4 weeks SIG ☐ 225 mg/dose every 2 weeks SIG ☐ 300 mg/dose every 2 weeks

SIG ☐ 375 mg/dose every 2 weeks

Step 10 Health Care Provider Certification

By submitting this form, I certify: (a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician. (b) If the indication for which this Genentech product is being prescribed to treat is not listed in the FDA-approved label, the prescriber is prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication for such a use. (c) The provider's office received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome. (d) The provider's office will not attempt to seek reimbursement for free product provided to the patient. (e) The services requested on behalf of the patient may include benefits investigation (BI), prior authorization (PA) and appeals support, co-pay card and co-pay assistance foundation referral. **(f) No action on these services will be taken until the patient consent document has been received.**

Sign, date & fax to **(800) 704-6612**

***Prescriber's Signature:** _____ ***Date:** ____/____/____

(Original or stamped signature required)