ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

URAC ACCREDITED SPECIALTY PHARMACY

Enroll via phone at: 800.906.7798
Enroll via fax at: 877.381.3806
E-prescribing NCPDP: 3982902
NPI: 1639103823 www.acropharmacy.com

XOLAIR ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 6.15.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

URAC ACCREDITED SPECIALTY PHARMACY

Enroll via phone at: 888.203.7973
Enroll via fax at: 888.203.7980
E-prescribing NCPDP: 1079638
NPI: 1598762015 www.commcarepharmacy.com

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)
Primary Insurance: Name of Insurer:_____ ID#:_____ BIN#: _____ PCN#:_____ Group#:_____ Phone:_____
Secondary Insurance: Name of Insurer:_____ ID#:_____ BIN#: _____ PCN#:_____ Group#:_____ Phone:_____

Medication Delivery to: (choose one) □Always to Physician's Office □Alternative Injection Center:_____

Diagnosis/Clinical Information

For Appropriate Patients With Allergic Asthma

Diagnosis Code: □J45.40 Moderate persistent asthma, uncomplicated □J45.50 Severe persistent asthma, uncomplicated □Other:_____

(Complete to the highest level of specificity)
Pretreatment serum IgE level IU/mL (1.0 kU/L=1.0 IU/mL; 2.4 ng/mL=1.0 IU/mL):
IgE level:_____ Test Date:_____ Patient Weight:_____ kg Weight Date:_____

□History of positive skin or RAST test to a perennial aeroallergen □Moderate to severe allergic persistent asthma
□Symptoms inadequately controlled with ICS

For Appropriate Patients With CIU

Diagnosis Code: □L50.1 Idiopathic urticaria Other:_____

(Complete to the highest level of specificity)
□Patient has had CIU for 6 weeks or more **Other CIU therapies:** □H1 antihistamines □Other:_____

Prescription Information

Prescription Type: □Naïve/New Start □Restart □Continued Tx Last Injection Date:_____

For Appropriate Patients With Allergic Asthma

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: Dispense XOLAIR subcutaneously
SIG□75mg/dose every 4 weeks SIG□150mg/dose every 4 weeks SIG□225mg/dose every 4 weeks SIG□300mg/dose every 4 weeks
SIG□225mg/dose every 2 weeks SIG□300mg/dose every 2 weeks SIG□375mg/dose every 2 weeks

For Appropriate Patients With CIU

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: Dispense XOLAIR subcutaneously
SIG□150mg/dose every 4 weeks SIG□300mg/dose every 4 weeks

Xolair Starter Program:
For eligibility criteria, please visit Genentech-Access.com/XOLAIR and/or speak to your XOLAIR representative. For assistance, call (800) 704-6610.

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation):_____ Date:_____ □Please select if you would like the patient enrolled in a Manufacturer's Assistance Program