



Enroll via phone at: 800.906.7798  
 Enroll via fax at: 877.381.3806  
 E-prescribing NCPDP: 3982902  
 NPI: 1639103823



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## XOLAIR ENROLLMENT FORM

Today's Date: \_\_\_\_\_  
 Needed By: \_\_\_\_\_

Last update 6.15.2018



Enroll via phone at: 888.203.7973  
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 E-prescribing NCPDP: 1079638  
 NPI: 1598762015



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<b>Patient Demographics:</b> (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: _____	<b>Provider Office:</b> (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: _____
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**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](http://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

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