



Xolair[®] (omalizumab) Enrollment Form

Please complete this form and fax to **866.823.9681**



1. PATIENT INFORMATION (Please print or type clearly)

Name _____ Today's Date _____
Street Address _____
City _____ State _____ Zip Code _____
Parent Guardian (if applicable) _____
Phone Numbers (Include Area Code): Day _____
Night _____ Cell Phone _____
Date of Birth _____ ☐ Male ☐ Female
Allergies _____
Primary Caregiver _____ Phone _____
Emergency Contact _____ Phone _____

INSURANCE INFORMATION: (Please include copies of insurance card - front & back)

Insurance Company Virginia Premier Health Plan, Inc. Phone 800.727.7536

Name of Cardholder _____

ID # _____ Group # _____

Relationship to Patient _____

2. PRESCRIBER INFORMATION

Prescriber _____

DEA # _____ NPI # _____

Facility Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____ Fax # _____

Form Submitted By _____

CONTACT: _____ Phone # _____

3. CLINICAL INFORMATION

Primary ICD-9 Code 0493. _____

(Please complete code to indicate status of asthmatic condition.)

Secondary ICD-9 Code _____

Concomitant therapies:

- | | |
|---|--|
| ☐ Short-acting Beta agonist | ☐ Leukotriene modifiers |
| ☐ Long-acting beta agonist | ☐ Nasal steroids |
| ☐ Antihistamines/decongestants | ☐ Oral steroids |
| ☐ Inhaled corticosteroid | ☐ Immunotherapy |
| ☐ Other _____ | |

Lab results: ☐ History of positive skin OR RAST test to a perennial aeroallergen

Pretreatment serum IgE level _____ IU per mL Test Date _____

Patient weight _____ Date weight obtained _____

☐ NKDA ☐ Known drug allergies _____

4. PRESCRIBING INFORMATION

Xolair[®] (omalizumab)

Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continued Therapy

- Administer: ☐ 150 mg/dose subcutaneously every 4 weeks
☐ 300 mg/dose subcutaneously every 4 weeks
☐ 225 mg/dose subcutaneously every 2 weeks
☐ 300 mg/dose subcutaneously every 2 weeks
☐ 375 mg/dose subcutaneously every 2 weeks

Dispense: ☐ 30-day supply ☐ 90-day supply
☐ Other _____

Refill _____ times

Place of Administration:

☐ Physician's Office ☐ Other _____

Other Location: _____

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

Ship to: ☐ Physician's Office

☐ Other _____

Address _____

City _____ State _____ Zip _____

☐ I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone or fax to the appropriate PBM.

By signing below, 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.

Prescriber's Signature _____ Date _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. 072613

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