Genentech | ACCESS SOLUTIONS
A Member of the Roche Group

for XOLAIR®
(omalizumab) for subcutaneous use

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **M-US-00012226(v1.0)**

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 health insurance cards.

Is prior authorization in place? ☐ Yes ☐ No Auth #: _____

	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 SPONTANEOUS URTICARIA ☐ L50.0 Allergic urticaria ☐ L50.1 Idiopathic urticaria ☐ L50.8 Other (chronic, recurrent) ☐ L50.9 Unspecified urticaria

NASAL POLYPS ☐ J33.0 Polyp of nasal cavity ☐ J33.1 Polypoid sinus degeneration ☐ J33.8 Other polyp of sinus ☐ J33.9 Nasal polyp, unspecified

Other diagnosis code: _____

Step 4 Acquisition and Administration Information

Dispense XOLAIR: ☐ Prefilled Syringe ☐ Vial Dispensing of XOLAIR through: ☐ Specialty pharmacy ☐ Buy and bill

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

Place of administration: ☐ Physician's office ☐ HOPD† ☐ Alternate injection center ☐ Patient's address

Ship to: ☐ Physician's office ☐ HOPD ☐ Alternate injection center ☐ Patient's address

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.**

†Hospital-based outpatient department.
‡National Provider Identifier.

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This page is OPTIONAL unless you are requesting the XOLAIR Starter Program for your patient. Please fully complete all fields.

Step 7 Patient Information (please re-enter)

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

Step 8 XOLAIR Starter Program (Prescriber signature required. Check all relevant boxes.)

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

☐ History of positive skin or RAST test to a perennial aeroallergen

☐ Symptoms inadequately controlled with inhaled corticosteroids (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 SPONTANEOUS URTICARIA (CSU)

☐ Patient has had CSU for 6 weeks or more

Other CSU therapies: ☐ H1 antihistamine ☐ Other: _____

NASAL POLYPS

☐ Patient has inadequate response to nasal corticosteroids

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

☐ **Other:** _____

Step 9 Prescription Information

Prescription type: ☐ **Naïve/new start** ☐ **Restart** **Last injection date (if applicable):** ____/____/____

Dispense XOLAIR: ☐ Prefilled Syringe ☐ Vial

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

Prescription: (Please check dosage and frequency)

FREQUENCY	Every 2 weeks			Every 4 weeks		
MG/DOSE:	☐ 225	☐ 300	☐ 375	☐ 75	☐ 150	☐ 225
	☐ 450	☐ 525	☐ 600	☐ 300	☐ 450	☐ 600

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 and fax to **(800) 704-6612**

***Prescriber's Signature:** _____ ***Date:** ____/____/____
(Original or stamped signature required)