XOLAIR (OMALIZUMAB) INJECTION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:		ZIP:
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Frequency	Refills
Xolair (omalizumab)	□ 75mg SubQ □ 150mg SubQ □ 225mg SubQ □ 300mg SubQ □ 375mg SubQ □ 450mg SubQ □ 525mg SubQ □ 600mg SubQ □ _____ mg SubQ	□ Every 2 weeks □ Every 4 weeks □ Every _____ weeks	□ x 1 year □ _____

Note: Patient must have an EpiPen in their possession on their appointment date

Other orders: _____

Lab Orders: _____ Frequency: _____
Required labs to be drawn by: □ LIVbetter □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR XOLAIR (OMALIZUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- □ Include signed and completed order (MD/prescriber to complete page 1)
- □ Include patient demographic information and insurance information
- □ Include patient's medication list
- □ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - □Please indicate any tried and failed therapies (if applicable):
    - □Corticosteroids _____
    - □Long acting beta 2 agonist _____
    - □Long acting muscarinic antagonist _____
    - □Antihistamines: _____
    - □Other: _____
  - □*Asthma* - Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? □ Yes □ No
  - □*Asthma* - Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? □ Yes □ No
  - □*Nasal polyps* - Does the patient have significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or loss of smell? □ Yes □ No
- □ Include labs and/or test results to support diagnosis
  - □ *Asthma, Polyps, & Allergy* - Does patient have a baseline IgE level of ⩾ 30 IU/mcL? □ Yes □ No **(required - attach results)**
  - □ *Asthma* - Does the patient have an allergy to a perennial aeroallergen? □ Yes □ No
  - □ Pulmonary Function Tests or FEV1 score (if applicable): _____
- □ Is the patient or caregiver able to administer Xolair for self-administration? (**UHC only**) □ Yes □ No If no, please state reason: _____
- □ Isthepatient a candidate for home therapy? (**UHC only**) □ Yes □ No
- □ Other medical necessity: _____