PARAGON HEALTHCARE

A Carelon Company

XOLAIR (OMALIZUMAB) INJECTION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis:

- ☐ Moderate Persistent Asthma (ICD-10: J45.40)
- ☐ Severe Persistent Asthma (ICD-10: J45.50)
- ☐ Allergic Urticaria (ICD-10: L50.0)
- ☐ Idiopathic Urticaria (ICD-10: L50.1)
- ☐ Urticaria, unspecified (L50.9)
- ☐ Polyp of the Nasal Cavity (ICD-10: J33.0)
- ☐ Polypoid Sinus Degeneration (ICD-10: J33.1)
- ☐ Nasal Polyp, unspecified (ICD-10: J33.9)
- ☐ Allergy to peanuts (ICD-10: Z91.010)
- ☐ Allergy to milk products (ICD-10: Z91.011)
- ☐ Allergy to eggs (ICD-10: Z91.012)
- ☐ Allergy to seafood (ICD-10: Z91.013)
- ☐ Allergy to other foods (ICD-10: Z91.018)
- ☐ Other: _____ (ICD-10: _____)

Patient Weight: _____ lbs. (required)

Allergies: _____

THERAPY ORDER

Xolair Dose:

☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg ☐ 450mg ☐ 525mg ☐ 600mg

Frequency: Subcutaneously Every: ☐ 2 weeks x 1 year OR ☐ 4 weeks x 1 year

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

Other orders: _____

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* 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.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

PARAGON HEALTHCARE

A Carelon Company

COMPREHENSIVE SUPPORT FOR XOLAIR (OMALIZUMAB) THERAPY

PATIENT INFORMATION:

Patient 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: _____
- ☐ Is the patient a candidate for home therapy? (**UHC only**) ☐ Yes ☐ No
- ☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance