



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

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				

Diagnosis Code ICD-10 (required):	Diagnosis Description:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> 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)	<input type="checkbox"/> 75mg SubQ <input type="checkbox"/> 150mg SubQ <input type="checkbox"/> 225mg SubQ <input type="checkbox"/> 300mg SubQ <input type="checkbox"/> 375mg SubQ <input type="checkbox"/> 450mg SubQ <input type="checkbox"/> 525mg SubQ <input type="checkbox"/> 600mg SubQ <input type="checkbox"/> _____ mg SubQ	<input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Every _____ weeks	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

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

Other orders: _____

Lab Orders: _____ Frequency: _____

Required labs to be drawn by: Paragon 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 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.

Prescriber Signature: X	Date:
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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/mL?
 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: _____