RECERTIFICATION REMINDER PROGRAM ENROLLMENT FORM FOR XOLAIR® (omalizumab) FOR SUBCUTANEOUS USE

M-US-00001253(v3.0) 11/22

Phone: (800) 704-6610 | **Fax:** (800) 704-6612 | **Website:** Genentech-Access.com/XOLAIR | **Customer Service Hours:** 6 a.m.–5 p.m. PT, Monday through Friday

The **XOLAIR Recertification Reminder Program** helps eligible patients avoid potential gaps in their XOLAIR therapy due to insurance recertification requirements. Once enrolled, you will be sent reminders via fax to recertify your patients for XOLAIR.

To enroll your practice in this program, please complete this form and fax it to **(800) 704-6612**. Please write legibly and complete all sections to prevent delays. By submitting this fax, you are requesting XOLAIR Access Solutions to enroll you in the XOLAIR Recertification Reminder Program.

PHYSICIAN

Physician's Last Name: _____ First Name: _____

NPI*: _____

*National Provider Identifier.

PRACTICE

Practice Name (use legal entity name): _____

Practice Contact Name†: _____

Street: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Group NPI: _____

☐ AIC‡: _____ ☐ **Buy and Bill**

†All Recertification Reminder Program communication will be sent to contact preference indicated here.
‡Alternate Injection Center.

The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Genentech, Inc. and Novartis Pharmaceuticals Corporation make no representation or guarantee concerning coverage or reimbursement for any service or item.

ADD ADDITIONAL PHYSICIANS AND/OR PRACTICES HERE *(please leave blank if none):*

NEW PHYSICIAN

Physician's Last Name: _____

First Name: _____

NPI: _____

NEW PHYSICIAN

Physician's Last Name: _____

First Name: _____

NPI: _____

NEW PRACTICE

Practice Name: _____

Practice Contact Name: _____

Street: _____

City: _____

State: _____ ZIP: _____

Phone: _____

Fax: _____

Email: _____

Group NPI: _____

NEW PRACTICE

Practice Name: _____

Practice Contact Name: _____

Street: _____

City: _____

State: _____ ZIP: _____

Phone: _____

Fax: _____

Email: _____

Group NPI: _____

Please use page 2 of this form to add additional physicians and/or practices.

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Please use this page to enroll additional physicians and/or practices. You may copy this page as necessary.

NEW PHYSICIAN

Physician's Last Name: _____

First Name: _____

NPI: _____

NEW PHYSICIAN

Physician's Last Name: _____

First Name: _____

NPI: _____

NEW PRACTICE

Practice Name: _____

Practice Contact Name: _____

Street: _____

City: _____

State: _____ ZIP: _____

Phone: _____

Fax: _____

Email: _____

Group NPI: _____

Practice Name: _____

Practice Contact Name: _____

Street: _____

City: _____

State: _____ ZIP: _____

Phone: _____

Fax: _____

Email: _____

Group NPI: _____

PERMISSION

☐ My patients have signed the Patient Consent Form, indicating they have given XOLAIR Access Solutions permission to contact them directly for missing or additional information. I do not have any objections to XOLAIR Access Solutions contacting my patients. This form is valid for 6 years, unless a shorter period is required by law.

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