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(v5.0)** **03/24**

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 the patient started therapy? ☐ Yes ☐ No

If the 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 insurance cards.

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

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
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.)

IgE-mediated Food Allergy
- ☐ Z91.010 Allergy to peanuts
- ☐ Z91.011 Allergy to milk products
- ☐ Z91.012 Allergy to eggs
- ☐ Z91.013 Allergy to seafood
- ☐ Z91.018 Allergy to other foods

Chronic Spontaneous Urticaria (CSU)
- ☐ L50.0 Allergic urticaria
- ☐ L50.1 Idiopathic urticaria
- ☐ L50.8 Other (chronic, recurrent) urticaria
- ☐ L50.9 Urticaria, unspecified

Allergic Asthma
- ☐ J45.40 Moderate persistent asthma, uncomplicated
- ☐ J45.50 Severe persistent asthma, uncomplicated

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
- ☐ 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: ☐ Autoinjector (≥12 years old) ☐ Prefilled Syringe ☐ Vial Dispensing of XOLAIR through: ☐ Specialty pharmacy ☐ Buy and bill

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

Place of administration/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 XOLAIR Co-pay Program Enrollment Criteria

☐ By checking this box, I certify that:

- I have the patient's consent to enroll in the Genentech XOLAIR Co-pay Program for assistance with drug out-of-pocket costs and/or Genentech XOLAIR administration out-of-pocket costs
- The patient is not using and I will not bill any federal- or state-funded health care program. This includes, but is not limited to, Medicare, Medicaid, Medigap, VA, DoD and TRICARE
- The patient is not currently receiving Genentech XOLAIR from the Genentech Patient Foundation
- The patient is not currently receiving assistance from any other charitable organization for any of their out-of-pocket costs that are covered by the Genentech XOLAIR Co-pay Program
- I have read and accepted the full Program Terms and Conditions as found at **XOLAIRcopay.com/terms-and-conditions**
- Genentech reserves the right to rescind, revoke or amend the program without notice at any time

DoD=Department of Defense; HOPD=hospital-based outpatient department; IgE=immunoglobulin E; VA=Veterans Affairs.

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Step 6 Patient Information (please re-enter)

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

Step 7 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: (____) ____-____

If you are a resident of a US state that provides certain rights with respect to your personal information, a complete description of the personal information we may collect and process, the purposes for which it is used by Genentech, and your rights under your state's privacy laws concerning your personal information can be found in our privacy notice at **www.gene.com/privacy-policy**.

Complete steps 8-10 ONLY if you are requesting the XOLAIR Starter Program. Signature and date are required at the bottom for this program only.

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

XOLAIR Starter Program supplies the first 30 days of medicine. If coverage decision is delayed past 3 weeks, we will follow up for 1 refill. Genentech reserves the right to rescind, revoke or amend the program without notice at any time. For full eligibility criteria and Terms and Conditions, please visit **www.Genentech-pro.com/starter** or speak to your Genentech representative.

IgE-mediated Food Allergy

☐ Clinical history consistent with IgE-mediated food allergy

☐ Positive specific IgE and/or positive skin prick test and/or Oral Food Challenge to allergenic food(s)

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)

Other CSU therapies: ☐ H1 antihistamine

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 Rhinosinusitis with Nasal Polyps (CRSwNP)

☐ 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: ☐ Autoinjector (≥12 years old) ☐ 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:	☐ 150	☐ 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 program referral or enrollment 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)

FDA=US Food and Drug Administration; IgE=immunoglobulin E; NPI=National Provider Identifier; RAST=radioallergosorbent test.

XOLAIR is a registered trademark of Novartis AG.