Prime THERAPEUTICS Pharmacy™

Xolair order form

Complete the following information and return to Prime Therapeutics Pharmacy LLC.

Please attach all prescriptions on official state prescription form if mandated by individual state laws. The prescriber is to comply with their state-specific prescription requirements such as ePrescribing, state-specific prescription form or hard copy prescription.

ePrescribers: Please note that we are a surescripts© network pharmacy.

Patient information *Please type or print clearly*	Name		DOB	☐ Male ☐ Female
	Street address			
	City		State	ZIP
	Home phone	Work		Cell
	Emergency contact	Phone		Relationship
Health conditions	Treatment diagnosis: ☐ J45.40 ☐ J45.50 ☐ L50.1 ☐ Other			
	☐ No known drug allergies ☐ Known drug allergies List:			
	Concurrent medications:			
	Concomitant therapies: ☐ Short-acting beta agonist ☐ Long-acting beta agonist			
	☐ Antihistamines ☐ Decongestants ☐ Immunotherapy ☐ Inhaled corticosteroid			
	☐ Leukotriene modifiers ☐ Oral steroids ☐ Nasal steroids ☐ Other			
Asthma only	Pretreatment serum IgE level: IU per mL			Test date:
	Patient weight: kg			Date weight obtained:
	Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continual therapy			

Insurance information	**Prescription benefit**		**Medical benefit**
	Insurance company		Insurance company
	Policy #		Policy #
	Policyholder name		Policyholder name
	Group #		Group #
	BIN #	PCN #	Customer service phone #
	Customer service phone #		
	Copay assist ID		
	☐ I consent to allow Prime Therapeutics Pharmacy to auto-enroll me in any patient assistance program.		

Prescription order *Prescription must be faxed from physician's office*	Medication	Formulation	Strength and directions	Qty/refills
	Xolair (Omalizumab) ☐ Asthma (dose and frequency are dependent upon serum IgE levels and weight, see package insert) ☐ Chronic idiopathic urticaria (fixed dose, not dependent upon weight or IgE levels)	**Prefilled syringe:** ☐ 75 mg/0.5 mL ☐ 150 mg/mL **Single-dose vial:** ☐ 150 mg lyophilized powder for reconstitution **Auto Injector** ☐ 75 mg/0.5 mL ☐ 150 mg/mL	**Every 4 weeks dosing:** ☐ Administer 75 mg per dose subcutaneously every 4 weeks ☐ Administer 150 mg per dose subcutaneously every 4 weeks ☐ Administer 225 mg per dose subcutaneously every 4 weeks ☐ Administer 300 mg per dose subcutaneously every 4 weeks ☐ Administer other: _____mg per dose subcutaneously every 4 weeks **Every 2 weeks dosing:** ☐ Administer 225 mg per dose subcutaneously every 2 weeks ☐ Administer 300 mg per dose subcutaneously every 2 weeks ☐ Administer 375 mg per dose subcutaneously every 2 weeks ☐ Administer other: _____mg per dose subcutaneously every 2 weeks	**Dispense:** ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
	Xolair supplies: • Sterile water for injection 10 mL vial for reconstitution • Administration Supply Kit consisting of: – (6) Alcohol preps – (3) 3 mL Luer lock injection syringe – (3) BD 25G x 5/8" needle for subcutaneous injection – (1) Package of Band-Aids – (3) BD 18G x 1" needle for reconstitution ☐ No supplies (Supplies will be sent with single dose vial shipment unless selected.)			

Prescriber information			
	• *I certify that the above therapy is medically necessary and the information is accurate to the best of my knowledge.* • *This request for services has been prepared exclusively by the provider or provider's office identified in this request ("my practice").* • *The prescribed medication is medically appropriate for the patient identified based on my best professional judgment and that my practice will be supervising the patient's treatment.* • *My practice has obtained written authorization from the patient identified in this request to disclose the patient's personal health information and any other information on this enrollment form as may be required by Prime Therapeutics Pharmacy to provide the services requested, as required to comply with all federal and state laws and regulations relating to medical and/or health privacy, including, but not limited to, the HIPAA Privacy Rule (codified at 45 C.F.R. Parts 160 and 164) and Confidentiality of Substance Use Disorder Patient Records Regulation (codified at 42 C.F.R. Part 2), as amended from time to time.*		
	Prescriber signature		Date
	Print prescriber name	Prescriber type ☐ MD ☐ DO ☐ PA ☐ NP	
	Prescriber NPI #	DEA #	License #
	Office contact		
	Street address/Suite number		
	City	State	ZIP
	Office phone	Office fax	

Generic equivalents are usually less expensive than brand-name drugs. If we dispense a brand-name drug, you may be responsible for a higher copay and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. ☐ **I do not accept a generic equivalent.**

6870 Shadowridge Drive, Ste 111, Orlando, FL 32812 | Phone: 866.554.2673 | Fax: 866.364.2673

***** This form is not valid in the state of Arizona. *****

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