

ALLERGIC ASTHMA

TELEPHONE 1-800-237-2767 FAX 1-800-323-2445

1. PATIENT INFORMATION *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)	Mobile Telephone # (+Area Code)	
Date of Birth (MM/DD/YYYY)		Social Security #	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

INSURANCE INFORMATION

Primary/Medical Insurance		Secondary/Pharmacy Insurance		
Cardholder Name & ID # (If Not Patient)		Cardholder Name & ID # (If Not Patient)		
Group/Policy #		Group/Policy #		
Insurance Telephone # (+Area Code)		Insurance Telephone # (+Area Code)		
Employer		Medicaid #		

ALTERNATE SHIPPING ADDRESS

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name		
Hospital/Clinic		Office Contact		
Street Address				
City		State	ZIP	
Telephone # (+Area Code)		Fax # (+Area Code)	E-Mail Address	
Prescriber's License #		DEA #	NPI #	
UPIN#		Medicaid License #		

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (Five Digit ICD-9 CM Code Plus Description Required)
 493.____ Asthma Other _____
 Asthma Severity **Severe Persistent** **Moderate Persistent** Mild Persistent Mild Intermittent
 New Start Continued Treatment

PERTINENT MEDICAL HISTORY:
 Concomitant Therapies (check all that apply)
 Short Acting Beta Agonist Inhaled Corticosteroid Oral Steroids
 Combination Therapy (LAB/ICH) Long Acting Beta Agonist
 Leukotriene Modifier Immunotherapy Theophylline
 Other: _____
 Other Allergies: _____
 NKDA
 Patient Weight ____ kg. OR ____ lbs. Date / /
 Pretreatment Serum Total IgE Level ____ IU/ml Test Date / /
 History of Positive Skin or RAST Test To a Perennial Aeroallergen Yes No

CLINICAL IMPRESSION:

Rx
 Xolair® (Omalizumab) 150 mg Vials and Sterile Water for Injection 10ml
 SIG ____ mg/Dose SQ Every 4 Weeks SIG ____ mg/Dose SQ Every 2 Weeks
 150 mg 300 mg 225 mg 300 mg 375 mg
 Other _____
 Maximum Supply Subject to Health Plan Benefit Limit
 30 Day Supply 90 Day Supply Quantity ____ Month(s) Supply
 Send To Physician's Address Patient's Address
 Other Location _____
Ancillary Supplies as Needed for Administration.

Refill: 12 Months Refill ____ Times Dispense As Written Substitution Allowed

Other Prescriber's Notes:

I certify that the rationale for Xolair therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.
Prescriber's Signature _____ **Date** _____

SPECIALTY: Allergist ENT Pediatrician
 Primary Care Pulmonologist Other _____

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.
Thank you for choosing Caremark!