OPTUM®

XOLAIR® REORDER FORM

Please complete for all patient refills and return with any pertinent patient information.

Fax: **1-866-926-0463** Phone: **877-409-9347**

For internal use only.

Image Indexing Team: Reference Category = Asthma/Allergy; Referral Source = Office Based Deliveries

PATIENT INFORMATION		
Name:	Date of birth:	
Insurance ID #:	Primary insurance name:	Secondary insurance name:
Address:		
City:	State:	ZIP:
Phone number:	Alternate phone:	Sex: ☐ Male ☐ Female
I confirm this is my current address and insurance information. Patient Initial here:_____		

PROVIDER AND SHIPPING INFORMATION		
Physician's name:	Physician ID (NPI/DEA):	
Address:		Suite number:
City:	State:	ZIP:
Phone number:	Fax:	
Contact name:	Phone:	Office Hours:

DELIVERY CONSENT

Date of last injection: ____/____/____

I received an injection of Xolair on the date shown above. Please ship my next Xolair shipment to the Provider Shipping address indicated above on the date indicated below. I authorize Optum® Specialty Pharmacy to bill my insurance company for the shipment and that I am financially responsible for any copay/coinsurance and amounts not covered by my insurance that is associated with these shipments. I understand that either myself, or an authorized representative will need to contact Optum Specialty Pharmacy at **1-866-863-7543** should circumstances change and I no longer need this next Xolair shipment or the shipment date changes for any reason.

Patient signature:_____

☐ I administered the injection of Xolair on the date shown above.

Physician office staff signature:_____

Requested delivery date: ____/____/____ Note: Tuesday–Friday only

Supplies to be included:

☐ Sterile water for injection ☐ Needle BD SYR 18G x 1.5" 3 ml ☐ Needle BD 25GX5/8"

Requestor name:_____ Title:_____

Requestor signature:_____ Date:_____

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