



# 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: <input type="checkbox"/> Male <input type="checkbox"/> 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 <b>1-866-863-7543</b> should circumstances change and I no longer need this next Xolair shipment or the shipment date changes for any reason.		
Patient signature: _____		
<input type="checkbox"/> 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:		
<input type="checkbox"/> Sterile water for injection	<input type="checkbox"/> Needle BD SYR 18G x 1.5" 3 ml	<input type="checkbox"/> Needle BD 25GX5/8"
Requestor name: _____	Title: _____	
Requestor signature: _____	Date: _____	

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