

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: [specialty@wellpartner.com](mailto:specialty@wellpartner.com)

Complete the following or include demographic sheet.

1. PATIENT INFORMATION		2. PRESCRIBER INFORMATION	
Name:		Name:	
Address:		DEA #:	NPI #: State Lic. #:
City, State, ZIP:		Group or Hospital:	
Primary Phone: - -	DOB: / /	Address:	
Alternate Phone: - -	Gender:	City, State, Zip:	
Email:		Phone: - -	Fax: - -
Primary Language:	Last Four of SSN:	Contact Person: Phone: - -	

**3. INSURANCE INFORMATION** *Fax copy of prescription and insurance cards with this form, if available (front and back)*

Primary Insurance Company Name:	Secondary Insurance Company Name:
Primary Cardholder Name:	Secondary Cardholder Name:
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent
Phone: - - Member ID: Group #:	Phone: - - Member ID: Group #:

**4. DIAGNOSIS AND CLINICAL INFORMATION**

Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	Concomitant Therapies:
<input type="radio"/> J45. _____ Description:	<input type="radio"/> Short acting beta agonist <input type="radio"/> Inhaled corticosteroid <input type="radio"/> Oral steroids <input type="radio"/> Combination therapy (LAB/ICH) <input type="radio"/> Long acting beta agonist <input type="radio"/> Theophylline <input type="radio"/> Leukotriene modifier <input type="radio"/> Immunotherapy <input type="radio"/> Other:
<input type="radio"/> Other:	Asthma Severity: <input type="radio"/> Intermittent <input type="radio"/> Mild persistent <input type="radio"/> Moderate to severe persistent
Height (in/cm): Weight (lb/kg):	Patient Type: <input type="radio"/> New start <input type="radio"/> Continued treatment
Medication Allergies:	If continuing treatment, has asthma control improved with treatment? <input type="radio"/> Yes <input type="radio"/> No
Concomitant Medications:	Is patient optimizing use of asthma controller or other medication? <input type="radio"/> Yes <input type="radio"/> No
	Is patient adherent to asthma controller or other medication? <input type="radio"/> Yes <input type="radio"/> No
	History of positive skin or RAST test to a perennial aeroallergen? <input type="radio"/> Yes <input type="radio"/> No
	Pretreatment serum total IgE level (IU/ml test): Date of Test: / /

**5. PRESCRIPTION INFORMATION**

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Xolair®	150 mg vial kit	Every 4 weeks dosing: <input type="radio"/> Administer 150 mg per dose SQ every 4 weeks. <input type="radio"/> Administer 300 mg per dose SQ every 4 weeks. <input type="radio"/> Administer _____ mg per dose SQ every 4 weeks. Every 2 weeks dosing: <input type="radio"/> Administer 225 mg per dose SQ every 2 weeks. <input type="radio"/> Administer 300 mg per dose SQ every 2 weeks. <input type="radio"/> Administer 375 mg per dose SQ every 2 weeks. <input type="radio"/> Administer _____ mg per dose SQ every 2 weeks. <input type="radio"/> Please supply one vial of sterile water (10 ml per vial) for every vial of Xolair dispensed and include ancillary supplies (syringe and needle, alcohol swabs).	<input type="radio"/> 30-day supply <input type="radio"/> 90-day supply <input type="radio"/> Other:	
<input type="radio"/> EpiPen®		Use as directed.		
<input type="radio"/> EpiPen® Jr.		Use as directed.		
<input type="radio"/> Nucala® (LD)* <input type="radio"/> CINQAIR® (LD)*	(LD)* These are limited distribution drugs that require additional handling. Please call (1.800.473.3516) for more information.			

Ancillary supplies and kits will be provided as needed for administration.

**6. PRESCRIBER SIGNATURE**

X _____ / /	X _____ / /
DISPENSE AS WRITTEN	PRODUCT SUBSTITUTION PERMITTED
DATE	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.