Hy-Vee Pharmacy SOLUTIONS

XOLAIR REFERRAL FORM

Phone: 877.794.9833 Fax: 855.861.4941
10004 S. 152nd St, Suite C, Omaha NE 68138

Patient Information

Last Name	First Name	DOB
Address		City
State	ZIP	Phone
SSN	Allergies	
Sex	Weight (kg)	Height (ft,in)
Emergency Contact	Phone	
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		City
State	ZIP	Phone
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact		Phone/Pager
Fax		Email

Prescriber Specialty: Allergist Pulmonologist ENT Primary Care Pediatrician Dermatologist Other:

Diagnosis/Clinical Information FOR APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA OR CIU

ICD-10-CM: J45.40 Moderate persistent asthma, uncomplicated J45.50 Severe persistent asthma, uncomplicated
L50.1 Idiopathic urticaria Other:

Concomitant therapies (check all that apply): Short acting beta agonist Long acting beta agonist Systemic glucocorticoids
H1 antihistamines Decongestants Immunotherapy Inhaled corticosteroid Leukotriene modifers Nasal steroids
Proton pump inhibitor H2 antagonist Other:

Allergic Asthma: History of positive skin or RAST test to a perennial aeroallergen Symptoms inadequately controlled with ICS
Pretreatment serum IgE level: __________IU/mL Date obtained: _______/_______/_______
Pretreatment FEV1 (if available): ____________% Date obtained: _______/_______/_______
Chronic Idiopathic Urticaria: Patient has had CIU for 6 weeks or more

Prescription type: Naive/New Start Restart Continued Treatment Last Injection Date: _______/_______/_______

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
Xolair - Allergic Asthma Every FOUR weeks dosing. *(dose dependent on weight and IgE levels)*	150mg single use vials Current weight: _________kg Weight date: ____/____/____	Administer 75mg/dose every 4 weeks Administer 150mg/dose every 4 weeks Administer 225mg/dose every 4 weeks Administer 300mg/dose every 4 weeks Other: Administer ______mg/dose every 4 weeks		
Xolair - Allergic Asthma Every two weeks dosing. *(dose dependent on weight and IgE levels)*	150mg single use vials Current weight: _________kg Weight date: ____/____/____	Administer 225mg/dose every 2 weeks Administer 300mg/dose every 2 weeks Administer 375mg/dose every 2 weeks Other: Administer ______mg/dose every 2 weeks		
Xolair - CIU *(fixed dose, not dependent on weight or IgE)*	150mg single use vials	Administer 150mg/dose every 4 weeks Administer 300mg/dose every 4 weeks Other: Administer ______mg/dose every 4 weeks		
EpiPen		Use as directed	2	
EpiPen Jr.		Use as directed	2	

Do you require diluent and supplies? No Yes -- 10mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringe as needed for reconstitution, 18-21 gauge needles as needed for reconstitution; 21-27 gauge needles as needed for administration

Date needed: _______/_______/_______ Medication delivery to (choose one): Prescriber Home Other:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: ______________________________

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) DISPENSE AS WRITTEN/Do Not Substitute (date)

I authorize Hy-Vee Pharmacy Solutions and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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