benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: ____________

☐ NEW PATIENT ☐ CURRENT PATIENT

XOLAIR REFERRAL FORM

PATIENT INFORMATION

Patient Name ____________

Address ____________

City ____________ State ____________ Zip ____________

Home Phone ____________ Cell ____________

DOB ____________ SSN ____________

Drug Allergies ____________ ☐ Male ☐ Female

Patient Weight: ____________ Height: ____________

PRESCRIBER INFORMATION

Prescriber Name ____________ DEA# ____________

NPI# ____________ Tax ID ____________

Practice Name ____________

Address ____________ Suite ____________

City ____________ State ____________ Zip ____________

Office Phone ____________ Fax ____________

Office Contact ____________

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance ____________

Policy # ____________ Group ____________

Insurance Phone ____________

Prescription Drug Coverage: Company ____________

Secondary Insurance (if applicable) ____________

Policy # ____________

Insurance Phone ____________

Phone ____________

RXGRP# ____________ RXBIN# ____________ PCN/ID# *(if available)* ____________

CLINICAL INFORMATION

Primary Diagnosis: ____________ ICD-10: ____________

Current Therapies: ☐ Antihistamines ☐ β agonist (☐ Long-acting ☐ Short-acting) ☐ Corticosteroids (☐ Inhaled ☐ Nasal ☐ Oral) ☐ Decongestants

☐ Immunotherapy ___ months ☐ Leukotriene modifiers ☐ Other ____________

Previous Treatment: ☐ Naïve ☐ Restart ☐ Continued therapy; date: ____________

Lab results: ☐ History of positive skin OR RAST test to a perennial aeroallergen ☐ Pretreatment serum IgE level________IU/mL; date____________ ☐ Other ____________

PLEASE ATTACH A LIST OF PATIENT'S CURRENT MEDICATIONS.

DRUG NAME	DOSE/FREQUENCY	DIRECTIONS FOR USE	QTY	REFILLS
☐ Xolair for Asthma	150 mg vial	Every 4 weeks Dosing Interval: ☐ Administer 150 mg subcutaneously every 4 weeks. ☐ Administer 300 mg subcutaneously every 4 weeks. ☐ Administer: ________ mg subcutaneously every 4 weeks. Every 2 weeks Dosing Interval: ☐ Administer 225 mg subcutaneously every 2 weeks. ☐ Administer 300 mg subcutaneously every 2 weeks. ☐ Administer 375 mg subcutaneously every 2 weeks. ☐ Administer: ________ mg subcutaneously every 2 weeks. ****Dose based on IgE level and weight. Please provide pertinent laboratory data.*	28-day supply	
☐ Xolair for CIU	150 mg vial	☐ Administer 150 mg subcutaneously every 4 weeks. ☐ Administer 300 mg subcutaneously every 4 weeks.	28-day supply	
☐ Xolair Supplies		10 mL vial of sterile water for injection per doses for reconstitution Supply Kit consisting of: • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL Luer Lock injection syringe • 18G x 1 1/2" needle for reconstitution • 25G x 5/8" needle for subcutaneous injection ☐ No supplies (Supplies will be sent with shipment unless indicated.)		
☐ EpiPen		Use as directed.		
☐ EpiPen Jr.		Use as directed.		

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

Statement of Medical Necessity: I certify the prescribed therapy is medically necessary. I will be supervising the patient's treatment accordingly and all information is accurate to the best of my knowledge. I authorize Benevere as my designated agent and on behalf of my patient to (1) provide any information on this form to the insurer of the above name patient and to (2) forward the above prescription by fax or other mode of delivery to the pharmacy chosen by the above named patient.

Prescriber's Signature (signature required. NO STAMPS) ____________ Date ____________

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