



CIGNA Specialty Pharmacy Services Xolair® Fax Order Form

Please deliver by: _____

Requests received after 4 p.m. CT will begin processing the following business day.

Order #: _____ Referral Source Code: **652**

Fax: 1.800.351.3616

Phone: 1.800.351.3606

PATIENT INFORMATION (Please Print)		PHYSICIAN INFORMATION	
PATIENT NAME:		DATE OF BIRTH :	
HEALTH CARE ID #:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F	
HOME PHONE:		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
WORK PHONE:	ALT PHONE:	TELEPHONE:	FAX:
ADDRESS: (Street) (City) (State) (Zip Code)		SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member's Home Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery.	
		*Is your fax machine kept in a secure location? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		*May we fax our response to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
ALLERGIES:		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If no allergies are specified, for new customers this indicates no known allergies and for existing customers this indicates no change from information provided to CIGNA Specialty Pharmacy previously.		LOCAL HOME HEALTH AGENCY:	TELEPHONE:

PRESCRIPTION INFORMATION

XOLAIR® 150 mg vial (omalizumab - J2357)

DIRECTIONS:

Every 4 Weeks Dosing:

- Inject 150mg SQ every four weeks
- Inject 300mg SQ every four week

- 1 month supply _____ refills
 - 3 month supply _____ refills
 - Other _____ Qty _____ refills
- **3 month supplies of medications can result in lower copays for the member**

Every 2 Weeks Dosing:

- Inject 225mg SQ every 2 weeks
- Inject 300mg SQ every 2 weeks
- Inject 375mg SQ every 2 weeks

- 1 month supply _____ refills
 - 3 Month supply _____ refills
 - Other _____ Qty _____ refills
- **3 month supplies of medications can result in lower copays for the member**

Other Dosing:

- 1 month supply _____ refills
 - 3 month supply _____ refills
 - Other _____ Qty _____ refills
- **3 month supplies of medications can result in lower copays for the member**

SUPPLIES NEEDED (if medication is to be administered in patient's home):

- Sharps Container
- Other (please specify): _____

Diluent, syringes, needles & alcohol swabs automatically included with medication

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

PHYSICIAN'S PRINTED NAME:

DATE:

PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)

PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:
MARK THE DIAGNOSIS:
<input type="checkbox"/> Asthma, Allergic, with stated cause <input type="checkbox"/> Asthma, Allergic, not otherwise specified <input type="checkbox"/> Other (<i>please specify</i>) _____
Does the patient have moderate/severe persistent asthma?? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient had a positive skin test or in-vitro reactivity to a perennial aeroallergen? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient inadequately controlled with inhaled corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No
Will the patient be treated with inhaled corticosteroids while taking Xolair? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify which medications: If no, please explain:
Will the patient be on another controller medication* while taking Xolair? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify which medication: If no, please explain:
*such as a long-acting agonist or a leukotriene receptor antagonist
ADDITIONAL PERTINENT INFORMATION:
In order for a brand name product to be dispensed, the prescriber must handwrite " Brand Necessary " or " Brand Medically Necessary " on the prescription