[Your Name]
[Your Title]
[Your Organization]
[Organization Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Recipient Name]
[Recipient Title]
[Recipient Organization]
[Recipient Address]
[City, State, ZIP Code]

Dear [Recipient Name],

I am writing to verify the eligibility of [Patient Name] for Xolair (Omalizumab) treatment. [Patient Name] has been under my care since [Date] for the management of [Condition/Diagnosis] and is experiencing [brief description of symptoms].

Based on [Patient's] medical history, I believe they meet the criteria for Xolair therapy, which includes [mention specific criteria such as age, condition severity, previous treatments attempted, etc.].

Please let me know if you require any additional information or documentation to facilitate the approval process.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Credentials]
[Your Organization]