Prescription Request for Xolair
Patient Information:
- Name: [Patient's Name]
- Date of Birth: [Patient's DOB]
- Address: [Patient's Address]
- Phone Number: [Patient's Phone Number]
Prescribing Physician:
- Name: [Physician's Name]
- NPI Number: [Physician's NPI]
- Phone: [Physician's Phone Number]
- Address: [Physician's Address]
Medication:
- Drug Name: Xolair (Omalizumab)
- Dosage: [Dosage as per guidelines]
- Route: Subcutaneous injection
- Frequency: [Specify frequency, e.g., every 2 or 4 weeks]
- Quantity: [Total quantity to dispense]
Indication:
- [Specify indication, e.g., moderate to severe asthma, chronic idiopathic urticaria, etc.]
Insurance Information:
- Insurance Provider: [Insurance Company]
- Policy Number: [Patient's Policy Number]
- Group Number: [Patient's Group Number]
Additional Instructions:
- [Any specific instructions regarding administration or storage]
Physician's Signature:
- [Signature]
- Date: [Date of Signing]
Contact Information for Pharmacy:
- Pharmacy Name: [Pharmacy Name]
- Pharmacy Phone Number: [Pharmacy Phone Number]
- Pharmacy Address: [Pharmacy Address]

Note: Ensure all placeholders are filled with accurate and specific information as needed.