I, _____, as treating physician for _____(date of birth:_____) am requesting Xolair®(Omalizumab) be dispensed by Accredo to the patient's home for subcutaneous administration during the COVID-19 pandemic.

I affirm:

- This individual is at high-risk for serious complications related to COVID-19.
- Alternative therapies (Benralizumab inj, Dupilumab inj, or Mepolizumab inj) have been considered and are not a preferred treatment option.
- I desire to continue this patient's Xolair treatment in the home setting via self/caregiver administration.
- This patient is appropriate for Xolair self-administration at home, has previously received three (3) or more doses of Xolair in a controlled setting and has no history of anaphylaxis.
- I am responsible for teaching the patient to self-administer, including how to recognize early signs and symptoms of serious allergic reactions (i.e. anaphylaxis).
- My intention is to move the patient's site of care back to the clinic when the COVID-19 threat passes.

My designated agent *(Name: _____)* have reviewed this patient's case with an Accredo Pharmacist and understand Accredo will confirm with patient the following prior to shipment:

- Patient is informed and aware of risks of Xolair administration outside of a controlled setting, including serious allergic reactions (i.e. anaphylaxis).
- Patient has been trained by physician on self-administration by subcutaneous injection, including how to recognize early signs and symptoms of serious allergic reactions (i.e. anaphylaxis). Accredo may reinforce any aspects of self-administration training as requested by patient.
- Patient has access to an active telephone and 911 service or a caregiver who has access to active telephone and 911 services.
- Patient will not be alone during administration of the Xolair medication (i.e. caregiver support) available.
- Patient has Epi-pen (epinephrine) for emergency use on hand. If not, I hereby authorize the Accredo pharmacy to provide the patient the appropriate Epi-pen for the purpose of emergency administration in the event of an allergic reaction.

_____

Printed Prescribers Full Name (First and Last)

_____

Signature Date

Fax to Accredo at 888-286-8954