Accredo Health Group, Inc.
1640 Century Center Parkway
Memphis, TN 38134

accredo®

Xolair® (omalizumab) Self-Administration Physician Attestation

I, ______________________________, as treating physician for ______________________________
Prescriber's full name & title *Patient's full name, including middle initial*

________________, am requesting Xolair® (omalizumab) be dispensed by Accredo to the patient's home for
Patient's DOB

subcutaneous administration.

I affirm:

Patient has no prior history of anaphylaxis, including to XOLAIR or other agents, such as foods, drugs, biologics, etc.

Patient has received at least 3 doses of XOLAIR under the guidance of a healthcare provider with no hypersensitivity reactions

Patient or caregiver is able to recognize symptoms of anaphylaxis

Patient or caregiver is able to treat anaphylaxis appropriately ***

Patient or caregiver is able to perform subcutaneous injections with XOLAIR prefilled syringe with proper technique according to the prescribed dosing regimen and Instructions for Use

____
Prescriber's Printed Full Name (First and Last)

______________________________ ________________
Signature Date

***Please complete Xolair Referral form at xolair.pdf (accredo.com) if a prescription for an Epi-Pen® is needed.

Fax to Accredo at 888.286.8954

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