

# XOLAIR Co-pay Program

## Verification of Administration

P.O Box 2106, Morristown, NJ 07962  
 Phone: (855) 965-2472  
 Fax: (866) 440-0599  
 www.XOLAIRcopay.com

As part of the request for patient reimbursement from The XOLAIR Co-pay Program, please provide the below information for the date of service referenced on the explanation of benefits (EOB), if the EOB does not clearly state that this patient received XOLAIR at your site on the date of service.

Patient name:	Member ID number:
Date of birth:	Today's Date:
Billing phone number:	
Primary contact's name (office financial manager):	Primary contact's title:
Primary contact's phone number:	Primary contact's fax number:
Additional physician names:	

Please provide the following information so we can determine the patient's out-of-pocket responsibility for XOLAIR.

Date of service: _____	
XOLAIR	
Number of vials administered: _____ 75mg PFS: _____ 150mg PFS: _____ Total dose administered: _____	
Total dose administered is reflective of the amount dispensed and does not include wastage.	
Drug Billed Amount: \$ _____	Injection Billed Amount \$ _____
<b>Authorization</b>	
Physician or office manager name:	Title:
Signature:	

Please fax this form back to (866) 440-0599 as soon as possible. We may be contacting you for additional information or clarification to determine patient eligibility. If you have any questions, please call (855) 965-2472.

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