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 $_____

Authorization	
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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