# Reimbursement Request Form
# XOLAIR Co-pay Program

**100 Passaic Avenue, Suite 245, Fairfield, NJ 07004**

**Phone: (855) 965-2472**
**Fax: (866) 440-0599**
**www.XOLAIRcopay.com**

Patient Name: ________________________________________ Date of Birth: ______________

Legally Authorized Person Name *(if applicable)*: ________________________________________

Provider Name: ________________________________________________________________

XOLAIR Co-pay Program Member ID: __________________ Drug Name: __________________

(Located on your Welcome Letter or at www.XOLAIRcopay.com)

**Reimbursement Payable to:**

□ Patient □ Legally Authorized Person □ Provider* (for drug out-of-pocket costs only)

Name: __________________________________________________________________________

Address: ________________________________________________________________________

City/State/ZIP: ____________________________________________________________________

Amount Requested: ________________________________________________________________

**If a provider completes the form, the Patient Attestation does not need to be signed.*

**Patient Attestation and Signature**

*I attest that I have commercial insurance, an on-label prescription for XOLAIR and will not seek reimbursement from my health insurance or other patient assistance programs. I also certify that, to the best of my knowledge, the information on this reimbursement request form is true and correct.*

Patient or Legally
Authorized Person Signature: ____________________________________________________

Date: __________________________________________________________________________

**Please fax the completed form along with the patient's detailed Explanation of Benefits (EOB) to the fax number above or mail to the address above.**

**A detailed EOB includes insurance carrier name and logo, name of the plan, patient's responsibility, date of service and drug code broken out by name, J-code or National Drug Code (NDC). For reimbursement to patient, a copy of the paid receipt must also accompany the above.**

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