XOLAIR Co-payProgram

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:
Office phone number:	
Office contact's name:	Office contact's title:
Office contact's fax number:	

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:_____ [DOSAGE] Total dose administered: _____
Total dose administered is reflective of the amount dispensed and does not include wastage.

Injection Billed Amount $_____

Authorization
Office contact's name:
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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