

c.	
d.	

13. Symptomatic (please indicate if the patient is actively symptomatic despite adequate adherence to above therapy):	
a. > 2 asthma symptom-days requiring bronchodilator therapy per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. > 2 asthma symptom-nights requiring bronchodilator therapy per month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. an asthma hospitalization within the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. an asthma ICU admission within past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. > 2 systemic steroid bursts within past 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. History of intubation (ever)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. # of ER visits for asthma in past 12 months?	

14. Recertification:

- Documentation of improvement in FEV1 % predicted, PEF, PFTs and decreased steroid requirement must be provided for continuation of therapy.

OR

- Documentation of improvement in symptoms or reduced frequency of exacerbations (especially hospital-based) even in the absence of PFTs or steroid requirement improvement.

Please provide an overall assessment of the magnitude of benefit, if any, from Xolair (or submit a copy of your most recent clinical assessment of the patient):

15. Prescriber Comments:

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature Date