Xolair Injection Order (omalizumab)

Fax completed order to: 334-521-0394

InfusionCare.org
P: 334-521-0073

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ H & P Relevant to the Diagnosis ☐ Current CBC ☐ Positive Skin Test or (RAST) to aeroallergen test ☐ IGE Labs ☐ fev1 / fvc test > 80% ☐ Medication List Including High-Dose ICS (Asthma) ☐ Asthmatics need to have Spirometry Results

This information is necessary for prior authorization approval and to ensure payment by the insurance carrier.

Patient Information

Date of Referral

First Name M.I. Last Name

Date of Birth

Address

City State Zip Code

Phone

Wt (kg) Ht (in)

Diagnosis

◯ J45.40 Moderate persistent asthma, uncomplicated
◯ J45.50 Severe persistent asthma, uncomplicated
◯ L50.1 Idiopathic urticaria
◯ L50.0 Allergic urticaria
◯ L50.8 Other (chronic, recurrent)
◯ L50.9 Unspecified urticaria
◯ J33.0 Polyp of nasal cavity
◯ J33.1 Polypoid sinus degeneration
◯ J33.8 Other polyp of sinus
◯ J33.9 Nasal polyp, unspecified

Office Contact Person

Office Contact Email or Phone Number

Xolair Dosing

Every 2 Weeks		
◯ 225mg	◯ 300mg	◯ 375mg
◯ 450mg	◯ 525mg	◯ 600mg

Every 4 Weeks		
◯ 225mg	◯ 300mg	◯ 375mg
◯ 450mg	◯ 525mg	◯ 600mg

Refill _______ times

***PER OUR PROTOCOL, Patient will be monitored for 2hrs after 1st injection, 1 hr after 2nd injection, then 20 mins thereafter injection.**

Prescribing Provider

Address

City State Zip Code

Provider Phone

Provider Fax

Provider NPI Provider Tax ID

PROVIDER SIGNATURE (NO STAMPS)

Date/Time