medix infusion

Xolair Order Form
(omalizumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ________________________________ DOB: ____________ Phone: ____________________ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: ____________________ Allergies: ____

Patient Preferred Location: ___________________________________

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

☐ J45.50 Severe Persistent Asthma, Uncomplicated
☐ J45.40 Moderate Persistent Asthma, Uncomplicated
☐ L50.1 Chronic Idiopathic Urticaria
Other: _______________________________

Allergic Asthma History

Positive RAST or Skin Test Test Date: ________
Pre-Treatment Serum IgE Test Date: ________

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include IgE levels AND RAST OR Skin Test for asthma diagnosis, if applicable.**

PRESCRIPTION

Xolair (omalizumab)

Dose: **(SELECT ONE)**
☐ **SubQ:** Inject 150 mg
☐ **SubQ:** Inject ______ mg

Frequency:
☐ Every 2 weeks for one year
☐ Every 4 weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first injection.

Comments: ____
____
____
____

PRESCRIBER INFORMATION

Prescriber Name: ____ ***Signature:*** ____

Date: ______________________ NPI #: ________________________________ Specialty: ____

Supervising Physician: ____ (If Applicable)

Address: ____ City: _____________________________ State: ___________ Zip:___________

Contact Name: _______________________ Phone: _______________ Fax: __________________ Email: ____________________________________