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: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

☐ J33.8 Other Polyp of Sinus

☐ 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 and 15 minutes following all subsequent injections.

Comments:

_____

_____

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____