medix infusion

Xolair Order Form
(omalizumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

- ☐ J33.8 Other Polyp of Sinus
- ☐ J45.50 Severe Persistent Asthma, Uncomplicated
- ☐ J45.40 Moderate Persistent Asthma, Uncomplicated
- ☐ L50.1 Chronic Idiopathic Urticaria
- ☐ Other: _____

Patient status:

- ☐ New to therapy
- ☐ Continuing therapy (date of last dose _____)

Weight: _____ ☐ lb ☐ kg Height: _____

Allergies: _____

PRESCRIPTION

XOLAIR (omalizumab)

Dose: ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg ☐ 450 mg ☐ 525 mg ☐ 600 mg

Frequency: ☐ Subcutaneously every 2 weeks for one year ☐ Subcutaneously every 4 weeks for one year

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

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

Other Orders:

_____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:
IgE levels AND RAST or Skin Test for asthma diagnosis, if applicable.

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____