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:** ______________________________

## <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)**

**Loading Dose (SELECT ONE)**

- **SubQ:** Inject 150 mg
- **SubQ:** Inject _____ mg

**Frequency**

- Every 2 weeks for one year
- Every 4 weeks for one year

**Is the patient on any other disease modifying therapy? Yes No**
**If yes, please note therapy and last dose: ______________________**

**Post Treatment Observations:** The patient is observed for 30 minutes following the first injection and 15 minutes following all subsequent administrations.

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

**Comments:**

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## PRESCRIBER INFORMATION

Prescriber Name: ______________________________ Signature: ______________________________

Date: __________ NPI #: ____________________ Specialty: ______________________

Supervising Physician: ________________________________________________ (If Applicable)

Address: ______________________ City: ______________________ State: ________ Zip: ________

Contact Name: ______________ Phone: ____________ Fax: ____________ Email: ______________