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

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 _____)

Medication Order

XOLAIR (omalizumab)

Dose: ☐ 75 mg ☐ 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

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

Comments: _____

Required Clinical Documentation

- **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**

LAB RESULTS: 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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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