

XOLAIR (OMALIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 New Start Therapy | Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

Asthma, ICD 10: J45. _____ Nasal Polyps, ICD 10: J33. _____
 Urticaria, ICD 10: L50. _____ IgE-mediated Food Allergy, ICD 10: Z91. _____
 Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Xolair	<input type="checkbox"/> 75 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 225 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 375 mg	Subcutaneous Inj	Every 2 weeks Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

CT: 203.433.0621
 FL: 904.877.9270

MA: 413.296.8482
 MD: 240.224.8607
 ME: 207.407.7272

NC: 919.984.8698
 NH: 603.217.5371
 NJ: 201.581.4521

NY: 631.250.6020
 OH: 937.871.4594
 PA: 610.273.5998

SC: 864.973.6279
 VA: 703.202.0499