Local Infusion

MYLOCALINFUSION.COM

XOLAIR (OMALIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

❑ Asthma, ICD 10: J45._____ ❑ Nasal Polyps, ICD 10: J33._____

❑ Urticaria, ICD 10: L50._____ ❑ IgE-medicated Food Allergy, ICD 10: Z91.01_____

❑ 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	❑ 75 mg ❑ 150 mg ❑ 225 mg ❑ 300 mg ❑ 375 mg	❑ Subcutaneous Inj	❑ Every 2 weeks ❑ Every 4 weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

OBSERVATION PERIOD

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ CT: 203.433.0621 ❑ ME: 207.407.7272 ❑ NH: 603.217.5371 ❑ NJ: 201.581.4521

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