

XOLAIR® (Omalizumab) Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

Patient Name

DOB

Height

Weight

Allergies

Patient Phone

Medical History

Positive perennial aeroallergen? Yes No

Asthma Symptoms controlled by corticosteroids? Yes No

Diagnosis (must include ICD-10 code)

Allergic Asthma _____ Asthma with acute exacerbation _____

Urticaria _____

Other (ICD-10 Code): _____

Date Diagnosed _____

Prescription Orders: XOLAIR® (Omalizumab) 150 mg vial

Sig: Inject Subcutaneously _____ mg every _____ week(s).

Anaphylaxis Protocol Orders: EpiPen 0.3mg Dispense #2 (Refills _____)

****Patients must carry EpiPen at all times.**

Refills: 12 months or for _____ injections

Provider Name

Phone

Fax

Provider's signature

Date

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.

For any other questions please call (469) 480-9649.

Or visit us online at www.ntinfusioncenters.com