

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



XOLAIR (omalizumab)

Infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

DIAGNOSIS *Please provide ICD-10 code*

_____ Allergic Asthma
 _____ Chronic Idiopathic Urticaria
 _____ (other)

PRE-MEDICATION

Tylenol 1000mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
 Cetirizine 10mg PO Diphenhydramine 25mg IVP

_____ (other) _____ (other)

SPECIAL INSTRUCTIONS

XOLAIR ORDERS

Dose:
 • 150mg /s 225mg/sq 300mg/sq 375mg/sq
 • other _____

Frequency:
 every 2 weeks every 4 weeks other _____

PATIENT WEIGHT

_____ lbs.
_____ kg

ALLERGIC ASTHMA HISTORY:

Positive RAST or SkinTest Test Date: _____ Other _____
 Pre-treatment Serum IgE: Lab Date: _____

TOTAL DOSES:

1 yr _____ Other _____ Refill _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____