

- Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218
- Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225
- Manhattan**
57W 57Street
Suite 601
New York, NY 10019
- Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030
- Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570
- Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523
- NYC Central Park West**
115 Central Park West
Suite 15
New York, NY 10023
- Woodbury**
75 Froehlich Farm
Woodbury, NY 11797
- Staten Island**
27 New Dorp Lane
Staten Island, NY 10306



- Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021
- Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375
- Manhattan**
225 East 70th Street
New York, NY 10021
- Holbrook/Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741
- Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583
- 5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559
- Long Beach**
917 Beech Street
Long Beach, NY 11561
- Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901
- Bronx**
226 West 238th Street
Bronx, NY 10463

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 _____