Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

ThrIVewell™
INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

XOLAIR (omalizumab)

Iinfusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
_____ *(other)*

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
_____ *(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 _____