

Hackensack
385 Prospect Avenue
Suite 101
Hackensack, NJ, 07601

Marlton
127 Church Road
Suite 203
Marlton, NJ 08053



Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Somerset
81 Veronica Avenue
Suite 202
Somerset NJ 08873

XOLAIR (omalizumab)

Infusion 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 | ☐ 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 _____