

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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 <i>Please provide ICD-10 code</i> ☐ _____ Allergic Asthma ☐ _____ Chronic Idiopathic Urticaria ☐ _____ (other) _____	XOLAIR ORDERS Dose: ☐ • 150mg /s ☐ 225mg/sq ☐ 300mg/sq ☐ 375mg/sq ☐ • other _____ Frequency: ☐ every 2 weeks ☐ every 4 weeks ☐ other _____
PRE-MEDICATION ☐ Tylenol 1000mg PO ☐ Solu-Medrol 125mg IVP ☐ Diphenhydramine 25mg PO ☐ Solu-Cortef 100mg IVP ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg IVP _____ (other) _____	PATIENT WEIGHT _____ lbs. _____ kg
SPECIAL INSTRUCTIONS 	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 _____