Local Infusion

MYLOCALINFUSION.COM

XOLAIR (OMALIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Asthma, ICD 10: J45._____ ❑ Nasal Polyps, ICD 10: J33._____

❑ Urticaria, ICD 10: L50._____ ❑ IgE-medicated Food Allergy, ICD 10: Z91._____

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Xolair	❑ 75 mg ❑ 150 mg ❑ 225 mg ❑ 300 mg ❑ 375 mg	Subcutaneous Inj	Every 2 weeks Every 4 weeks

LABS / SPECIAL INSTRUCTIONS