Xolair

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

◯ Labs (IgE level) ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

ICD-10 CODE

◯ J45.40 Moderate persistent asthma ◯ J45.50 Severe persistent asthma ◯ J33.9 Nasal polyps

◯ L50.1 Urticaria, Idiopathic ◯ L50.8 Chronic Urticaria ◯ Z91.010 Allergy to peanuts

◯ Z91.011 Allergy to milk products ◯ Z91.012 Allergy to eggs ◯ Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO **Diphenhydramine** (Benadryl) ◯ 25mg ◯ 50mg ◯ PO ◯ IV

Cetirizine (Zyrtec) ◯ 10mg PO **Methylprednisolone** (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

Loratadine (Claritin) ◯ 10mg PO **Hydrocortisone** (Solu-Cortef) ◯ 100mg IV

Other: _____ Dose:_____ Route:_____ Frequency: _____

MEDICATION ORDER

Xolair (omalizumab) **Dose:** ◯ 75mg ◯ 150mg ◯ 225mg ◯ 300mg ◯ 375mg ◯ 450mg ◯ 525mg ◯ 600mg **Route:** subcutaneous injection (SC) **Frequency:** ◯ every 2 weeks ◯ every 4 weeks

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ◯ Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

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