Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

XOLAIR INJECTION ORDER

Please fax a copy of patient's demographics, insurance information, current lab results, H&P relevant to diagnosis & current medications including high dose ICS. Please also fax the completed Statement of Medical Necessity form. (Asthmatics need to have spirometry results)

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD 10: _____

Xolair Dosage: (omalizumab)
150 mg/ vial

_____ mg subcutaneous

Frequency: ☐ Q 2 weeks ☐ Q 4 weeks

IGE level (asthmatics) : _____

**** PER OUR PROTOCOL, ALL PATIENTS MUST HAVE EPINEPHRINE AUTO INJECTOR WITH THEM AT TIME OF INJECTION.**
Patient will be monitored for 30 minutes after injection

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office phone number: _____ Office Fax:_____

Office address: _____Contact person: _____