Phone: (805) 719-3700
Fax: (805) 413- 9099
Website: infusionforhealth.com

XOLAIR INJECTION ORDER

Please fax a copy of patient's:

□ Demographics **□ Copy of Insurance Cards**
□ Current Lab Results **□ H & P Relevant to Diagnosis**
□ Medication List Including High-Dose ICS (Asthma)
□ 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 (omalizumab) Dosage:
Pre-filled syringe

_____ 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: _____