Xolair Injection Order

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ______ / ______ / ________ Treatment Location: ______________________________

***Please fax a copy of the following patient information:**

- ☐ Demographics
- ☐ Insurance Information
- ☐ H & P Relevant to the Diagnosis
- ☐ Current Lab Results
- ☐ Medication List Including High-Dose ICS *(Asthma)*
- ☐ Completed Statement of Medical Necessity Form
  (Asthmatics need to have Spirometry Results)

PATIENT INFORMATION

Patient Name: ______________________________

DOB: ______ / ______ / ________

Allergies: ______________________________

Weight: __________ lbs / kg Height: __________

Diagnosis: ______________________________

ICD-10: ______________________________

PROVIDER INFORMATION

Printed Provider's Name: ______________________________

Signature: ______________________________

NPI: ______________ Date: ______ / ______ / ________

Phone: (____) ______ - ______ Fax: (____) ______ - ______

Office Address: ______________________________

Contact Person: ______________________________

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 INFECTOR WITH THEM AT TIME OF INJECTION. Patient will be monitored for 30 minutes after injection.**

Revised 12/01/20