Xolair Injection Order

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Demographics, Insurance Information, H & P Relevant to the Diagnosis
Current CBC, Positive Skin Test or (RAST) to aeroallergen test,
IGE Labs, fev1 / fvc test > 80%, Medication List Including High-Dose ICS *(Asthma)*
Completed Statement of Medical Necessity Form
(Asthmatics need to have Spirometry Results)

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis:
- ☐ J45.40 moderate persistent asthma
- ☐ J45.50 severe persistent asthma
- ☐ J32.9 chronic sinusitis unspec.
- ☐ L50.1 idiopathic urticaria

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

XOLAIR DOSAGE

Date of Last Treatment, If Continuation: _____

Pre-filled syringe

_____ mg subcutaneous

Frequency: ☐ Q 2 weeks ☐ Q 4 weeks

IGE level (asthmatics): _____

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

Revised 09/08/23