

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Most Recent Office Visit Note, Insurance Information, Serum IgE Results (unless using for diagnosis of CSU)

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): J45.40 J45.50 J33. ____ L50. ____ Z91. ____ ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

Center will use Hypersensitivity protocol established by Infusion for Health and PI

Serum IgE level (list date & results): _____

LABORATORY ORDERS

CBC at each dose every _____

CMP at each dose every _____

Other: _____ Frequency: _____

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.

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

Diphenhydramine 25mg / 50mg PO / IV

Acetaminophen 325mg / 500mg / 650mg PO

Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

THERAPY ADMINISTRATION

Xolair Subcutaneous Injection
 Dose: 75mg 150mg 225mg 300mg
 375mg 450mg 525mg 600mg
 Frequency:
 Every 2 weeks / Every 4 weeks / Other: _____

Refills: Zero / for 12 months / _____
 (if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) _____ Provider Signature _____ Date _____

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.