Xolair (Omalizumab) Referral Form

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)
☐ Documentation of any tried and failed therapies

Patient Name:	**DOB:**	**Weight:**
Allergies:	**Patient Phone:**	

Diagnosis:
☐ Allergic Asthma (ICD-10 _____)
☐ Chronic Idiopathic Urticaria (ICD-10 _____)
☐ Other (ICD-10 _____)

Xolair Dose: ☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg ☐ 450 mg ☐ 600 mg ☐ Other: _____

Frequency: subcutaneously every ☐ 2 weeks ☐ 4 weeks

Refill: ☐ PRN x 1 year OR _____ times

History of Allergic Asthma:

Positive Skin or RAST Test ☐ Yes ☐ No Test Date: _____

Pretreatment IgE Serum: _____ IU/mL Test Date: _____

Date of last Xolair injection: _____
Note: Patient must have EpiPen in their possession on their appointment date.

Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician

Labs: _____ Frequency: _____

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed ☐ N/A

Nursing Orders: ☐ Pharmacy to provide nursing services for initial administration and teaching and as needed ☐ N/A

Additional Instructions:

Practitioner Name:	**Practitioner Signature:**	**Date:**

Practitioner Address: