

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:		

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MISSISSIPPI

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