

**MEDICATION ORDERS- XOLAIR (OMALIZUMAB)**

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

\*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>  
 Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Severe Eosinophilic Asthma      ICD 10 Code: J45.50 <input type="checkbox"/> Chronic Idiopathic Urticaria      ICD 10 Code: L50.1 <input type="checkbox"/> Other: _____      ICD 10 Code: _____

REQUIRED DOCUMENTATION
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Pulmonary Function Tests (asthma only) <input type="checkbox"/> Serum IgE level <input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Perennial aeroallergen test or skin test results (asthma only)

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)
- 3)

MEDICATION ORDERS**	
Severe Eosinophilic Asthma Dosing	Please indicate dose in blank space below, in increments of 75mg, based on the pretreatment eosinophil count and body weight. <input type="checkbox"/> Xolair _____ mg SubQ every 2 weeks <input type="checkbox"/> Xolair _____ mg SubQ every 4 weeks
Chronic Idiopathic Urticaria Dosing	<input type="checkbox"/> Xolair 150mg SubQ every 4 weeks <input type="checkbox"/> Xolair 300mg SubQ every 4 weeks
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

\*\*Pharmacy will dispense the correct size and amount of syringes for each dose.

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	