Xolair[®]

Provider Order Form Rev. 02/2024

Please fax completed referral form & all required documents to (833) 786-0025



		PATIEN	IT DEMOGRAPHICS				
Patient Name:				Phone:			
					Height: ☐ in ☐ cm		
				-	Holgin Lin Lin Lin		
Patient Status:	inew to Thei		-				
		INSURANCE INFORMATION: P	DIAGNOSIS*	card (<u>Irontand Dack</u>).			
	☐ Moderate As	sthma (J45.40-J45.42), ICD10					
*100.40.0-4-		ma (J45.50-J45.52), ICD10		☐ Other Urticaria, L50.8 ☐ Allergy to milk products, Z91.011			
*ICD 10 Code Required		S (J33.0-J33.9), ICD10					
•	☐ Other:	, ICD10			lergy to seafood, Z91.013 lergy to other foods, Z91.018		
		INF	USION ORDERS	□ 7(I	lergy to other loods, 291.010		
MEDICATION DOSE			DIRECTIONS/DURATION				
□ Ca		□ mg	Inject SUBQ every we	_ weeks x 1 year			
		☐ Calculate dose and frequency			ing first Xolair doses, and then		
		per patient weight and IgE level	for 30 minutes after all subsequent doses □ Established patient: Observe patient for 30 minutes after each dose				
			☐ Established patient. Of	oserve patient for 50 min	utes after each dose		
Is patient currently another facility?	y receiving ther	apy above from	, Facility Name:				
☐ Yes ☐ No		Date	of last treatment:	Date of next tr	eatment:		
PRE-MEDICATION	ON ORDERS		LAB ORDERS				
☐ No premeds or	dered at this time		Labs to be drawn by:	☐ Infusion Center	☐ Referring Physician		
☐ Acetaminopher	650mg PO	☐ Diphenhydramine 25mg PC	☐ No labs ordered at	t this time			
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydroc		OR- Hydrocortisone 100mg IVP	□ CBC q	☐ CMP q	☐ CRP q		
☐ Other:			□ ESR q	☐ LFTs q	☐ Other:		
		REFERRING I	PHYSICIAN INFORMAT	ION			
Physician Signatur	e.						
		Date: NPI: Specialty:					
			City/ST/Zip:				
			#: Fax #:				
		ation Should Be Sent:					
		REQUIRED CLINICAL DOCUMENTATION					
			LINICAL DOCUMENTAT				
Please attac	h medical reco				ts to support diagnosis.		
		rds: Initial H&P, current MD pro			ts to support diagnosis.		
	ESULTS for AST			st, and labs/test resul	ts to support diagnosis.		
LAB AND TEST R ☐ Pre-treatment I	ESULTS for AST gE level	rds: Initial H&P, current MD pro	ogress notes, medication lis ☐ Pre-treatment pulm ☐ FEV-1 <80% p	st, and labs/test resul monary function test: predicted			
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