XOLAIR (OMALIZUMAB) Referral Form

FAX (877) 637-6691

VASCO INFUSION
WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)* _____

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

XOLAIR MEDICATION ORDERS

Dosing: ☐ 375mg ☐ 300mg ☐ 225mg ☐ 150mg

Other: _____

Frequency: ☐ SC every 2 weeks ☐ SC every 4 weeks

Refills: _____

INDICATION/DIAGNOSIS

☐ Moderate persistent asthma, uncomplicated - J45.40
☐ Severe persistent asthma, uncomplicated - J45.50
☐ Chronic Idiopathic Urticaria (CIU) - L50.1
☐ ***Requirement: Patient has an unexpired EPI pen at time of injection and is competent in its use.***

***ICD-10 _____ required**

NOTES (ADDITIONAL INFO)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW *ASTHMA* REFERRALS ONLY)

☐ Positive Skin or RAST test to a perennial allergan ☐ Pretreatment IgE level 10/ml

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY

10/2018