XOLAIR (OMALIZUMAB) Referral Form FAX (877) 637-6691

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: ____________________________

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

INDICATION/DIAGNOSIS

☐ J45.40 Moderate persistent asthma, uncomplicated
☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Chronic Idiopathic Urticaria (CIU)
☐ ***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