

# Xolair (omalizumab)

Provider Order Form rev. 5/20/2022



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## PATIENT INFORMATION

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
<b>Patient Status:</b>	New to Therapy	Continuing Therapy	Therapy Change
	Next Due Date (if applicable):		

## PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

## DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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### ICD-10 CODE

- J45.40 Moderate persistent asthma
- J45.50 Severe persistent asthma
- J33.9 Nasal polyps
- L50.1 Urticaria, Idiopathic
- L50.8 Chronic Urticaria
- Other: \_\_\_\_\_

### MEDICATION ORDER

**Xolair** (omalizumab)

Dose:

75mg	150mg	225mg
300mg	375mg	450mg
525mg	600mg	

Route: subcutaneous injection (SC)

Frequency:

Every 2 weeks

Every 4 weeks

Order Expiration Date (mm/dd/yy): \_\_\_\_\_

(If not indicated order will expire one year from date signature)

## SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order