

# XOLAIR

Please include the following to expedite the order:

Patient Demographics, Insurance Information, Labs

## PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Other \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

## PRESCRIBER

Prescriber Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_ State License: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## CLINICAL

Diagnosis: ☐ J45.50 (Severe Persistent Asthma) ☐ J45.51 (Severe Persistent Asthma with acute exacerbation)  
☐ L50.1 (Chronic Spontaneous Urticaria) ☐ Other: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ ☐ kg ☐ lbs Height: \_\_\_\_\_ ☐ cm ☐ in

Pretreatment Total IgE: \_\_\_\_\_ IU/mL Date: \_\_\_\_\_

## TREATMENT

### XOLAIR (omalizumab)

Route: Subcutaneous Injection

Dose: ☐ 75mg ☐ 150mg ☐ 225mg  
☐ 300mg ☐ 375mg ☐ 450mg  
☐ 525mg ☐ 600mg ☐ Other: \_\_\_\_\_

Frequency:

☐ Every 2 weeks  
☐ Every 4 weeks  
☐ Other: \_\_\_\_\_

Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

### Premedication Protocol: (Not Usually Indicated)

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV  
☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO  
☐ Other: \_\_\_\_\_

Sig: \_\_\_\_\_

☒ Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_