

**XOLAIR (omalizumab)**

|                                  |  |   |       |       |
|----------------------------------|--|---|-------|-------|
| <b>Status</b>                    | <input type="checkbox"/> New Therapy <input type="checkbox"/> Order Renewal <input type="checkbox"/> Dosage or Frequency Change  |   |       |       |
| <b>Diagnosis</b>                 | <input type="checkbox"/> ICD 10 Code: J45.50   | Severe persistent asthma, uncomplicated |       |       |
|                                  | <input type="checkbox"/> ICD 10 Code: L50.8  | Chronic idiopathic urticarial (CIU)     |       |       |
|                                  | <input type="checkbox"/> ICD 10 Code: _____  | Other: _____                            |       |       |
| <b>Pertinent Medical History</b> | <b>Initial Requests:</b> IgE level: _____ Date: _____  |   |       |       |
|                                  | For <b>Asthma</b> : Patient has had a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids? <input type="checkbox"/> Y <input type="checkbox"/> N |   |       |       |
|                                  | For <b>CIU</b> : Patient remains symptomatic despite H1 antihistamine treatment? <input type="checkbox"/> Y <input type="checkbox"/> N   |   |       |       |
|                                  | <b>Renewal Requests:</b>   |   |       |       |
|                                  | 1. Did the patient experience measurable evidence of improvement in disease activity and/or severity? (Provide documentation) <input type="checkbox"/> Y <input type="checkbox"/> N  |   |       |       |
| <b>Labs</b>                      | Labs to be drawn by: <input type="checkbox"/> Infusion Clinic <input type="checkbox"/> Referring Physician   |   |       |       |
|                                  | If Infusion Clinic: _____  |   |       |       |
| <b>Medication Order</b>          | Xolair SubQ injection  |   |       |       |
|                                  | Dose: <input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg <input type="checkbox"/> 375mg  |   |       |       |
|                                  | Frequency: <input type="checkbox"/> every 2 weeks <input type="checkbox"/> every 4 weeks <input type="checkbox"/> other: _____   |   |       |       |
|                                  | Refills: <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses <input type="checkbox"/> No refills; give this dose only.  |   |       |       |
| <b>Monitoring</b>                | Monitor for signs/symptoms of hypersensitivity during injection and 15 mins post-injection.<br>For any signs of infusion reaction: Contact on-site provider for instruction.   |   |       |       |
| <b>Additional Orders</b>         |  |   |       |       |
| <b>Physician Information</b>     | Physician Name   | _____                                   | NPI   | _____ |
|                                  | Office Contact   | _____                                   | Phone | _____ |
|                                  | Provider Signature:  | _____                                   | Date  | _____ |

| <b>REQUIRED DOCUMENTATION</b>   |  |
|---|--|
| <input type="checkbox"/> Patient Demographics & <b>Insurance</b> Information:             | <ul style="list-style-type: none"> <li>- Copy of patient's insurance card – front and back</li> </ul>  |
| <input type="checkbox"/> <b>Clinical / Progress Notes</b> , supporting primary diagnosis: | <ul style="list-style-type: none"> <li>- 2 most recent office notes (including inadequate asthma control)</li> <li>- Medication history</li> </ul> |
| <input type="checkbox"/> Most Recent <b>Labs</b> :  | <ul style="list-style-type: none"> <li>- IgE Lab results</li> <li>- FEV1 test results</li> </ul>   |

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