# Xolair
(omalizumab)

Advanced Infusion Care Centers

## PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

## PRIMARY DIAGNOSIS

☐ J33.0 Polyp of nasal cavity
☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Idiopathic urticaria
☐ Z91.010 Allergy to peanuts
☐ Z91.011 Allergy to milk products
☐ Z91.012 Allergy to eggs
☐ Z91.013 Allergy to seafood
☐ Z91.018 Allergy to other foods
☐ Other: _____

## PRESCRIPTION

**Xolair Dose**

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

**Frequency**

Subcutaneously every: ☐ 2 weeks x 1 year **OR** ☐ 4 weeks x 1 year

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

## REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Most Recent Labs
- Tried/Failed Therapies
- Patient Demographics

## ANCILLARY ORDERS

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol
*(See aiscaregroup.com for detailed policy)*
- Epinephrine (weight-based dosing) PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

### PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this medication.
☐ Provider Prescribed: _____

### LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*