Xolair Injection Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ☐ J45.40 Modern persistent asthma, uncomplicated
- ☐ J45.50 Severe persistent asthma, uncomplicated
- ☐ L50.0 Allergic urticaria
- ☐ L50.1 Idiopathic urticaria
- ☐ L50.8 Other (chronic) urticaria
- ☐ L50.9 Urticaria, unspecified
- ☐ J33.0 Polyp of nasal cavity
- ☐ J33.1 Polypoid sinus degeneration
- ☐ J33.8 Other polyp of sinus
- ☐ J33.9 Nasal polyp, unspecified
- ☐ Z91.010 Allergy to peanuts
- ☐ Z91.011 Allergy to milk product
- ☐ Z91.012 Allergy to eggs
- ☐ Z91.013 Allergy to seafood
- ☐ Z91.018 Allergy to other foods

Patients weight: _____

XOLAIR ORDER

Xolair Dose: ◯ 150mg ◯ 225mg ◯ 300mg ◯ 375mg ◯ 450mg ◯ 525mg ◯ 600mg

Frequency: ☐ Subcutaneously every 2 weeks ☐ Subcutaneously every 4 weeks

Pre-treatment IGE serum: _____IU/ml

Date of last Xolair Injection: _____

*** **NOTE:** Patient **must have** an EpiPen/ epinephrine in their possession at each appointment date.***

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____