vitalcare of CENTRAL MISSISSIPPI

Fountains Infusion Center

Phone: 601.859.8200 Fax: 601.859.8201

XOLAIR (OMALIZUMAB) INJECTION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Allergic Asthma (ICD-10: _____)

☐ Chronic Idiopathic Urticaria (ICD-10: _____)

J Code: J2357

Pt. Weight _____ kg Allergies:_____

XOLAIR ORDERS

Xolair Dose: ☐ 150mg ☐ 250mg ☐ 300mg ☐ 375mg

Frequency: Subcutaneously Every: ☐ 2 weeks or ☐ 4 weeks

History of Allergic Asthma: Positive Skin or RAST Test: ☐ Yes ☐ No
Test Date:_____

Pre-Treatment IgE Serum:_____IU/ml Test Date:_____

****Date of last Xolair Injection:_____**
Note: Patient must have and EpiPen in the possession on their appointment date.

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	