Omalizumab (Xolair)

Provider Order Form rev. 10/5/2021

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ☐ J45.50 (severe persistent asthma, uncomplicated) ☐ L50.8 (Chronic urticaria) ☐ Other

If Other, give ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Serum IgE level and date resulted (results)

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☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☑ **Omalizumab** (Xolair)

- Dose: ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg
- Route: subcutaneous injection
- Frequency: ☐ every 2 weeks ☐ every 4 weeks / ☐ other: ________________________

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ____________________
(if not indicated order will expire one year from date signed)

OBSERVATION/EPI PEN (PLEASE SELECT BELOW)

☐ Patient is required to have Epi Pen with each treatment
☐ Patient is NOT required to have Epi Pen
☐ Patient is required to stay for 30 minutes observation period
☐ Patient is NOT required to stay for observation time
☐ Other:
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Determine dose (mg) and dosing frequency by serum total IgE level (IU/mL) measured before the start of treatment, and by body weight (kg).
Because of the risk of anaphylaxis, observe patients closely for an appropriate period of time after XOLAIR administration.

Provider Name (Print) **Provider Signature** **Date**

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

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