

# Omalizumab (Xolair)

Provider Order Form rev. 3/25/2022



## PATIENT INFORMATION

Date:	Patient Name:	DOB:		
ICD-10 code (required):	<input type="checkbox"/> J45.50 (severe persistent asthma, uncomplicated)	<input type="checkbox"/> L50.8 (Chronic urticaria)	<input type="checkbox"/> Other	
If Other, give ICD-10 description:				
<input type="checkbox"/> NKDA Allergies:				Weight lbs/kg:
<b>Patient Status:</b> <input type="checkbox"/> New to Therapy	<input type="checkbox"/> 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)  
\_\_\_\_\_
- 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](http://www.ivxhealth.com/forms) (version 09.07.2021)

## 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)

## SPECIAL INSTRUCTIONS

## 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:  
\_\_\_\_\_

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
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### FAX NUMBERS

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> CHICAGO: 312-253-7244    | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN/AR: 888-615-1445   |  |
| <input type="checkbox"/> COLUMBUS: 844-627-2675   | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> RALEIGH: 919-287-2551      | <input type="checkbox"/> MIDDLE TN: 888-615-1445    |  |
| <input type="checkbox"/> BAY AREA: 844-889-0275   | <input type="checkbox"/> DAYTONA: 386-259-6096      | <input type="checkbox"/> KANSAS CITY: 844-900-1292  | <input type="checkbox"/> SARASOTA: 941-870-6550     | <input type="checkbox"/> EAST TN: 615-425-7427 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143  | <input type="checkbox"/> HARRISBURG: 844-859-4235   | <input type="checkbox"/> ORLANDO: 844-946-0867      | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 |  |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARTFORD: 860-955-1532     | <input type="checkbox"/> PALM BEACH: 561-768-9044   | <input type="checkbox"/> TAMPA: 844-946-0849        |  |