

# Omalizumab (Xolair)



Provider Order Form rev. 08/21/2023

## PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

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): Height:

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)
- ☒ 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 05.01.2023)

## 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
- ☐ 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

## FAX NUMBERS

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> AUSTIN: 512-772-2824     | <input type="checkbox"/> CONNECTICUT: 860-955-1532    | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> NORTH CENTRAL FL: 352-756-4191 | <input type="checkbox"/> RALEIGH: 919-287-2551      |
| <input type="checkbox"/> BAY AREA: 844-889-0275   | <input type="checkbox"/> DAYTONA: 386-259-6096        | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> NORTH JERSEY: 551-227-2823     | <input type="checkbox"/> SAN ANTONIO: 726-238-9950  |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143  | <input type="checkbox"/> DELAWARE: 302-596-8553       | <input type="checkbox"/> KANSAS CITY: 844-900-1292  | <input type="checkbox"/> NORTHWEST AR: 888-615-1445     | <input type="checkbox"/> SARASOTA: 941-870-6550     |
| <input type="checkbox"/> CHICAGO: 312-253-7244    | <input type="checkbox"/> EAST TN: 615-425-7427        | <input type="checkbox"/> LAKELAND: 863-316-3910     | <input type="checkbox"/> ORLANDO: 844-946-0867          | <input type="checkbox"/> SOUTH JERSEY: 856-519-5309 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> LITTLE ROCK: 501-451-5644  | <input type="checkbox"/> PALM BEACH: 561-768-9044       | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 |
| <input type="checkbox"/> COLUMBUS: 844-627-2675   | <input type="checkbox"/> HARRISBURG: 844-859-4235     | <input type="checkbox"/> MIAMI: 786-744-5687        | <input type="checkbox"/> PHILADELPHIA: 844-820-9641     | <input type="checkbox"/> TAMPA: 844-946-0849        |
|   | <input type="checkbox"/> HOUSTON: 832-631-9595        | <input type="checkbox"/> MIDDLE TN: 888-615-1445    | <input type="checkbox"/> PIEDMONT TRIAD: 336-790-2200   | <input type="checkbox"/> WEST TN: 888-615-1445      |