Xolair (Omalizumab)

☐ New Referral ☐ Restart ☐ Medication Order Change

PATIENT INFORMATION

Name ______________________

Date ______________________

DOB ______________________

SS# ______________________

Phone # ______________________

Email ______________________

PHYSICIAN INFORMATION

Referring Physician ______________________

Practice Address ______________________

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Office Contact Name ______________________

Contact Phone # ______________ Fax # ______________

NPI / TIN ______________ ______________

MEDICATION ORDERS

Dosing: ☐ 375mg ☐ 300mg ☐ 225mg ☐ 150mg

☐ Other: ______________

Frequency: ☐ SC every 2 weeks ☐ SC every 4 weeks

Indication / Diagnosis:

☐ J.45.40 Moderate persistent asthma, uncomplicated

☐ J.45.50 Severe persistent asthma, uncomplicated

☐ L50.1 Chronic Idiopathic Urticaria (CIU)

☐ ***Requirement: Patient has an unexpired EPI pen at time of injection and is competent in its use.***

ICD-10 (Required) ______________________

MD Signature ______________________ Date ______________

Additional Information:

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REQUIRED DOCUMENTATION

Please send the following documents and records. This will help streamline the pre-authorization process.

- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- If this is a continuation of a treatment, include the last infusion note
- Current medication list

Most recent diagnostics results to include:

- Eosinophil phenotype (EOS) (drawn within the last 3 months)
- If available, radioallergosorbent test (RAST) results

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.