



Xolair (Omalizumab)

INFUSION THERAPY CENTERS

New Referral Restart Medication Order Change

PATIENT INFORMATION

Name _____
Date _____
DOB _____
SS# _____
Phone # _____
Email _____

PHYSICIAN INFORMATION

Referring Physician _____
Practice Address _____

Office Contact Name _____
Contact Phone # _____ Fax # _____
NPI / TIN _____

MEDICATION ORDERS

Dosing: 375mg 300mg 225mg 150mg Frequency: SC every 2 weeks SC every 4 weeks
 Other: _____

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.**

Additional Information:

ICD-10 (Required) _____

MD Signature _____ Date _____

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.

AZIVinfusion.com | CALL CENTER: 602.386.4968 | FAX: 623.594.8533

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Flagstaff, AZ 86001

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Gilbert, AZ 85234

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