aleracare
advanced infusion centers™

FAX 833.329.4738

Xolair (omalizumab)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ J45.40 Moderate persistent asthma ◯ J45.50 Severe persistent asthma ◯ J33.9 Nasal polyps

◯ L50.1 Urticaria, Idiopathic ◯ L50.8 Chronic Urticaria ◯ Other: _____

Medication Order

Xolair (omalizumab) **Dose:** ◯ 75mg ◯ 150mg ◯ 225mg ◯ 300mg ◯ 375mg ◯ 450mg ◯ 525mg ◯ 600mg **Route:** subcutaneous injection (SC) **Frequency:** ◯ every 2 weeks ◯ every 4 weeks

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯