MIC | METRO INFUSION CENTER

MEDICATION ORDERS- XOLAIR (OMALIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Severe Eosinophilic Asthma	ICD 10 Code: J45.50
☐ Chronic Idiopathic Urticaria	ICD 10 Code: L50.1
☐ Other: ____________________________________	ICD 10 Code: ________________

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Pulmonary Function Tests (asthma only)	☐ Perennial aeroallergen test or skin test results (asthma only)
☐ Serum IgE level	
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS**	
Severe Eosinophilic Asthma Dosing	Please indicate dose in blank space below, in increments of 75mg, based on the pretreatment eosinophil count and body weight. ☐ Xolair ___________ mg SubQ every 2 weeks ☐ Xolair ___________ mg SubQ every 4 weeks
Chronic Idiopathic Urticaria Dosing	☐ Xolair 150mg SubQ every 4 weeks ☐ Xolair 300mg SubQ every 4 weeks
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

**Pharmacy will dispense the correct size and amount of syringes for each dose.

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Send a referral via fax at 866-507-1164 or email to the MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.