OMALIZUMAB (Xolair)

MIC | METRO INFUSION CENTER

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

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE	
☐ Severe Eosinophilic Asthma	ICD10 : J45.50
☐ Chronic Idiopathic Urticaria	ICD10 : L50.1
☐ Other:	ICD10:

IgE-mediated Food Allergy ☐ Allergy to peanuts (ICD10: Z91.010) ☐ Allergy to milk products (ICD10: Z91.011) ☐ Allergy to eggs (ICD10: Z91.012)	☐ Allergy to seafood (ICD10: Z91.013) ☐ Allergy to other food (ICD10: Z91.018)

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

MEDICATION ORDERS	
********LATEX ALLERGY** ☐ **YES** ☐ **NO**	
Severe Eosinophilic Asthma Dosing OR IgE-mediated Food Allergy	*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*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ **(if not indicated order will expire one year from date signed)*	

SPECIAL INSTRUCTIONS

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

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

Revised 10/8/24

Provider Name (Print) **Physician Signature:** **Date:**

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