

Omalizumab (Xolair)

Provider Order Form rev. 3/1/2023



14107 Cortez Blvd
Brooksville FL 34613
P: (352)549-9962
F: (352)549-9963
www.360infusioncenter.com
E: info@360infusioncenter.com

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): J45.50 (severe persistent asthma, uncomplicated) L50.8 (Chronic urticaria) Other _____

If Other, give ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

- Serum IgE level and date resulted (results) _____
- Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

THERAPY ADMINISTRATION

- Omalizumab (Xolair)
 - Dose: 75mg 150mg 225mg 300mg 375mg
 - Route: subcutaneous injection
 - Frequency: every 2 weeks every 4 weeks /
 - other: _____
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

OBSERVATION/EPI PEN (PLEASE SELECT BELOW)

- Patient is required to have Epi Pen with each treatment
- Patient is NOT required to have Epi Pen
- Patient is required to stay for 30 minutes observation period
- Other: _____

Determine dose (mg) and dosing frequency by serum total IgE level (IU/mL) measured before the start of treatment, and by body weight (kg).
Because of the risk of anaphylaxis, observe patients closely for an appropriate period of time after XOLAIR administration.

Provider Name (Print)

Provider Signature

Date