XOLAIR
(omalizumab)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

• Has patient had results of a positive skin test or in vitro reactivity to a perennial aeroallergen? ☐ Y ☐ N Date of Test:_____
• For idiopathic urticaria: Has the patient remained symptomatic despite H1 antihistamine treatment? ☐ Y ☐ N

PRIMARY DIAGNOSIS

☐ J33.0 Polyp of nasal cavity
☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Idiopathic urticaria
☐ Z91.010 Allergy to peanuts
☐ Z91.011 Allergy to milk products
☐ Z91.0120 Allergy to eggs, unspecified
☐ Z91.013 Allergy to seafood
☐ Z91.018 Allergy to other foods
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Xolair
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Xolair subQ Injection

☐ Xolair _____mg subQ injection every 2 weeks
☐ Xolair _____mg subQ injection every 4 weeks
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

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