

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
 ALLERGIES:     SEE LIST                       NKDA                      WEIGHT:                       LB    OR                       KG

**REQUIRED DOCUMENTATION**

1. Insurance Card    2. History & Physical                      3. Patient Demographics                      4. Medication List                      5. Most Recent Labs  
 6. Has patient had results of a positive skin test or in vitro reactivity to a perennial aeroallergen?     Yes     No    Date of Test: \_\_\_\_\_  
 7. For idiopathic urticaria: Has the patient remained symptomatic despite H1 antihistamine treatment?     Yes     No

**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                       Z91.012 Allergy to eggs  
 Z91.013 Allergy to seafood                       Z91.018 Allergy to other foods  
 Other \_\_\_\_\_

**LABS 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?:     Yes     No     Refill x12 months unless otherwise noted.

**LINE USE/CARE ORDERS**

Start PIV/ACCESS CVC                       Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)  
 Other Flush Orders: Please send other line care orders if checking this box

**ADVERSE REACTION & ANAPHYLAXIS ORDERS**

Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)  
 Other: (Please send other reaction orders if checking this box)

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 OFFICE CONTACT: \_\_\_\_\_ FAX: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
 CITY, STATE, ZIP: \_\_\_\_\_ NPI AND LICENSE: \_\_\_\_\_

**X**  
 PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_