LIFE SPECIALTY SOLUTIONS

XOLAIR
(omalizumab)

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
☐ L50.1 Idiopathic urticaria
☐ Z91.011 Allergy to milk products
☐ Z91.013 Allergy to seafood
☐ J45.50 Severe persistent asthma, uncomplicated
☐ Z91.010 Allergy to peanuts
☐ Z91.012 Allergy to eggs
☐ 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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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: _____

✖ _____ _____

PROVIDER SIGNATURE DATE