XOLAIR (OMALIZUMAB)
INJECTION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/Progress Notes, Labs & Tests supporting primary diagnosis

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- ☐ Allergic Asthma (ICD-10: _____)
- ☐ Chronic Idiopathic Urticaria (ICD-10: _____)

J Code: J2357

Pt weight: _____ kg

Xolair Orders

Xolair Dose: ☐ 150 mg ☐ 250 mg ☐ 300 mg ☐ 375 mg

Frequency: Subcutaneously every: ☐ 2 weeks or ☐ 4 weeks

History of Allergic Asthma: Positive Skin or RAST test: ☐ Yes ☐ no
Test Date: _____

Pre-treatment IgE Serum: _____IU/ml Test Date: _____

****Date of last Xolair Injection:_____**

Additional Instructions:

Physician Name:	Phone:	Fax:

Physician Signature:	Date: