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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 Allergies: _____

XOLAIR ORDERS

Xolair Dose: 150mg 250mg 300mg 375mg

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:** _____

Note: Patient must have and EpiPen in the possession on their appointment date.

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	