

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm
Patient Status: New to Therapy Dose or Frequency Change Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

***ICD 10 Code Required**

<input type="checkbox"/> Moderate Asthma (J45.40-J45.42), ICD10 _____	<input type="checkbox"/> Idiopathic Urticaria, L50.1
<input type="checkbox"/> Severe Asthma (J45.50-J45.52), ICD10 _____	<input type="checkbox"/> Other Urticaria, L50.8
<input type="checkbox"/> Nasal Polyps (J33.0-J33.9), ICD10 _____	<input type="checkbox"/> Unspecified Urticaria, L50.9
<input type="checkbox"/> Other: _____, ICD10 _____	

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Xolair® (omalizumab)	<input type="checkbox"/> _____ mg <input type="checkbox"/> Calculate dose and frequency per patient weight and IgE level	Inject SUBQ every _____ weeks x 1 year <input type="checkbox"/> New patient: Observe patient for 2 hours following first Xolair doses, and then for 30 minutes after all subsequent doses <input type="checkbox"/> Established patient: Observe patient for 30 minutes after each dose

Is patient currently receiving therapy above from another facility?

If yes, Facility Name: _____
 Date of last treatment: _____ Date of next treatment: _____

Yes No

PRE-MEDICATION ORDERS

No premeds ordered at this time
 Acetaminophen 650mg PO Diphenhydramine 25mg PO
 Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IVP
 Other: _____

LAB ORDERS

Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____
 ESR q _____ LFTs q _____ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ Provider NPI: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

See Attached Medical Records

LAB AND TEST RESULTS for ASTHMA DIAGNOSIS (required)

Pre-treatment IgE level Other: _____
 Positive skin or RAST test to a perennial aeroallergen
 Pre-treatment pulmonary function test
 FEV-1 <80% predicted
 FEV-1 reversibility ≥12% and 200mL after albuterol administration

LAB AND TEST RESULTS for NASAL POLYPS (required)

Diagnostic work-up (Attach report or imaging study): Other: _____
 Nasal endoscopy Anterior rhinoscopy Sinus CT scan
 Pre-treatment IgE level

LAB AND TEST RESULTS for URTICARIA DIAGNOSIS (required)

Baseline Urticaria Activity Score Other: _____

PRIOR FAILED THERAPIES

Medication Failed: _____	Dates of Treatment: _____	Reason for D/C: _____
Medication Failed: _____	Dates of Treatment: _____	Reason for D/C: _____
Medication Failed: _____	Dates of Treatment: _____	Reason for D/C: _____
Medication Failed: _____	Dates of Treatment: _____	Reason for D/C: _____
Medication Failed: _____	Dates of Treatment: _____	Reason for D/C: _____