OKLAHOMA INFUSION SERVICES

1701 Renaissance Blvd, Ste. 110
Edmond, OK 73013-5853
Phone: (405) 844-4978; Fax: (405) 844-0562

omalizumab (XOLAIR ®) Order Form

Patient's Information

Patient's Name:	Patient's Date of Birth:	Patient's Phone:	Gender: M ☐ F ☐
Patient's Address:	Patient's Email:	Insurance:	

Additional Information

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ J45.40 Moderate Persistent Asthma, Uncomplicated (6 years of age and older)
☐ J45.50 Severe Persistent Asthma, Uncomplicated (6 years of age and older)
☐ Uncontrolled with Inhaled Corticosteroid: ☐ Yes ☐ No
☐ L50.1 Idiopathic Urticarial (12 years of age and older)
☐ Symptomatic Despite H1 Antihistamine Treatment for 6 weeks: ☐ Yes ☐ No

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Positive skin test to perennial aeroallergen: ☐ Yes ☐ No Test Date: _____ Results: _____
☐ Positive RAST test: ☐ Yes ☐ No Test Date: _____ Results: _____
☐ Pre-treatment IgE serum: ☐ Yes ☐ No Test Date: _____ Level: _____
☐ Date of last Xolair injection: _____
☐ Severe hypersensitivity reaction to previous dose of Xolair or any ingredient of Xolair? ☐ Yes ☐ No

Lab Orders

☐ Lab Orders: ☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ Total IgE ☐ Other _____
☐ Lab Orders to be drawn by: ☐ Oklahoma Infusion Services ☐ Referring Provider

Prescription Information

☐ Xolair

☐ Vial (lyophilized powder) ☐ PFS (prefilled syringe)
Dose: ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ Subcutaneously every 4 weeks
Dose: ☐ 225mg ☐ 300mg ☐ 375mg ☐ Subcutaneously every 2 weeks
Dose: ☐ Other _____ mg ☐ Subcutaneously every _____ weeks
☐ *Note: Patient must have EpiPen in their possession on their appointment date*

Pre-Medication Orders

☐ Solu-Cortef 50-100mg SIVP ☐ Benadryl 25mg PO PRN
☐ Tylenol tablet 500-1000mg PO PRN ☐ No routine premedication necessary

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus ☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Notify supervising physician and ordering provider ☒ Oxygen 2-5L nasal cannula
☒ Solu-Cortef 100mg SIVP signs of adverse reaction ☒ Albuterol 2.5mg inhaled PRN for chest tightness
☒ Benadryl 25mg SIVP for hives or bronchial inflammation ☐ Other: _____

Prescriber's Information		Prescriber's Contact Person
Prescriber's Name:		Contact Name:
NPI #:	DEA #:	Contact Phone:
Prescriber's Signature:		Contact Fax:
Date:		

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.