Phone and Fax: 608-690-7210
Email: info@MySmartInfusion.com
www.MySmartInfusion.com

Xolair (Omalizumab)
Subcutaneous Injection Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____ Allergies to Latex: ☐ Yes ☐ No

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Severe Eosinophilic Asthma ICD 10 Code: J45.50

☐ Chronic Idiopathic Urticaria ICD 10 Code: L50.1

☐ Other: _____ ICD 10 Code: _____

Required Tests (within 12 months & attach results)

☐ Serum IgE Level

☐ Pulmonary Function Test (asthma only)

☐ Perennial Aeroallergen Test or Skin Test (asthma only)

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Special Instructions / Notes

Xolair Medication Order

Patient Weight: _____ KG

Dosage – Subcutaneous Injection

☐ 75mg ☐ 150mg ☐ 225mg

☐ 300mg ☐ 375mg ☐ Other _____

Frequency

☐ Every 2 weeks

☐ Every 4 weeks

☐ Other _____

Required Documents

☐ Patient Demographic Sheet

☐ H & P within the past 6 months

☐ Current Medication List

☐ Clinical and Progress Notes

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____