PRESCRIPTION ORDER FORM

XOLAIR
(omalizumab)

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

• Has patient had results of a positive skin test or in vitro reactivity to a perennial aeroallergen? ☐ Y ☐ N Date of Test:_____
• For idiopathic urticaria: Has the patient remained symptomatic despite H1 antihistamine treatment? ☐ Y ☐ N

PRIMARY DIAGNOSIS

☐ J33.0 Polyp of nasal cavity
☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Idiopathic urticaria
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐Solu-Medrol 125mg IVP ☐Solu-Cortef 100mg IVP ☐ Other: _____

PRIMARY MEDICATION ORDER

Xolair SubQ Injection

☐ Xolair _____mg SubQ injection every 2 weeks
☐ Xolair _____mg SubQ injection every 4 weeks
☐ Other:_____

**Dosing for patients 12 years old and greater.*

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol
(See suitelifehealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date