INFUSACARE
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Xolair (Omalizumab) Injection Order

Patient Name: _____ DOB: _____ □Male □Female

Diagnosis (please provide ICD10 code): _____

□ Other: _____

□ NKDA □ Allergies: _____

□ New Therapy Order □ Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Cetirizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other: _____

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Serum IgE results, level and date
□ CBC/CMP
□ Does patient require Epipen during appointment? Yes/No
□ Other: _____

Patient Height and Weight:

Patient Height (cm): _____ Patient Weight (kg): _____

Xolair Medication Order (Please select ONE):

- Subcutaneous Dosing (Please choose one):
  - □ 75 mg
  - □ 150 mg
  - □ 225 mg
  - □ 300 mg
  - □ 375 mg
  - □ 450 mg
  - □ 525 mg
  - □ 600 mg
- Frequency (Please choose one):
  - □ Every 2 weeks
  - □ Every 4 weeks
  - □ Other: _____
- Duration (Please choose one):
  - □ For _____ doses
  - □ For 12 months
  - □ Other: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:
□ *Skokie, IL*: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
□ *Libertyville, IL*: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400