Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Xolair (Omalizumab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Serum IgE level and date resulted (results)

_____

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

THERAPY ADMINISTRATION

☐ **Omalizumab** (Xolair)

- Dose: ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg
- Route: subcutaneous injection
- Frequency: ☐ every 2 weeks ☐ every 4 weeks /
- ☐ other: ☐ Refills: ☐ Zero /☐ for 12 months / ☐ _____

(if not indicated order will expire one year from date signed)

OBSERVATION/EPI PEN (PLEASE SELECT BELOW)

☐ Patient is required to have Epi Pen with each treatment
☐ Patient is NOT required to have Epi Pen
☐ Patient is required to stay for 30 minutes observation period
☐ Other: _____

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

_____ _____ _____

Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK