Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

Xolair Injection

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

For patients with Asthma ONLY:

Does the patient currently use tobacco products? ☐ Yes ☐ No

Has compliant use of current maintenance therapy been effective? ☐ Yes ☐ No please select all that apply:

- ☐ Oral steroids or increase in current maintenance steroid dosing was required
- ☐ Exacerbation resulted in an ED visit and/or hospitalization
- ☐ Increased need for rescue inhaler

Has patient been compliant on high dose ICS/LABA inhaler for at least 3 months? ☐ Yes ☐ No

What is the patient's blood IgE level prior to starting Xolair? _____ IU/mL; Date drawn: _____

In the past 6 months, what medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use

Xolair (*omalizumab*) Subcutaneous Injection Dosage:

Prefilled syringe will be used unless insurance mandates using vials

☐ _____ **mg**

Frequency: ☐ **Every 2 weeks** ☐ **Every 4 weeks**
☐ **Other:**_____

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____