Xolair (omalizumab)

Provider Order Form rev. 5/20/2022

AleraCare
A Healthcare Solutions Company
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PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ J45.40 Moderate persistent asthma

☐ J45.50 Severe persistent asthma

☐ J33.9 Nasal polyps

☐ L50.1 Urticaria, Idiopathic

☐ L50.8 Chronic Urticaria

☐ Other: _____

MEDICATION ORDER

Xolair (omalizumab)

Dose:

☐ 75mg ☐ 150mg ☐ 225mg

☐ 300mg ☐ 375mg ☐ 450mg

☐ 525mg ☐ 600mg

Route: subcutaneous injection (SC)

Frequency:

☐ Every 2 weeks

☐ Every 4 weeks

Order Expiration Date (mm/dd/yy): _____

(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

☐ **Check here if this is a stat order**