alera care
advanced infusion centers™

FAX 833.329.4738

Xolair (omalizumab)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ___________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

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
Z91.010 Allergy to peanuts
Z91.011 Allergy to milk products
Z91.012 Allergy to eggs
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

Documentation Required (Note: Send all labs, must include specific labs listed here)

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

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

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Patient Information

Patient Name:	DOB:	Sex: M F	Fasting: Y N
Patient Home Phone:	Patient Cell Phone:		
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:		

Lab Test (Please circle or write in ICD-10)

Lab Test	ICD-10	Lab Test	ICD-10
ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CALCIUM	M81.0, M81.8	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	PSA	R97.20, C61, N40.1, Z12.5, N40.0
CREATININE	M81.0, M81.8, G35	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
G6PD	M1A.9XX0, M1A.9XX1	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
GROWTH HORMONE	E22, C7A.1, E34	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	

Frequency

Prior to each dose   Yearly   Other: Please Specify Below

Lab Test: ____________________ Frequency: ____________________

Lab Test: ____________________ Frequency: ____________________

Lab Test: ____________________ Frequency: ____________________

Lab Test: ____________________ Frequency: ____________________

Provider Name ____________________

Provider Signature ____________________

Date ____________________

Provider Phone ____________________