NORTH TEXAS INFUSION CENTERS

XOLAIR® (Omalizumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____
Patient Name **DOB**

_____ _____ _____ _____
Height **Weight** **Allergies** **Patient Phone**

Medical History
☐ Positive perennial aeroallergen? ☐ Yes ☐ No
☐ Asthma Symptoms controlled by corticosteroids? ☐ Yes ☐ No

Diagnosis (must include ICD-10 code)
☐ Allergic Asthma_____ ☐ Asthma with acute exacerbation_____
☐ Other (ICD-10 Code):_____
Date Diagnosed_____

Prescription Orders: XOLAIR® (Omalizumab) 150 mg vial

Sig: Inject Subcutaneously_____mg every _____week(s).

Anaphylaxis Protocol Orders: ☐ EpiPen 0.3mg ☐ Dispense #2 (Refills_____)
****Patients must carry EpiPen at all times.**

Refills: ☐ 12 months ☐ _____injections

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436. Contact us directly at: (214) 276-5642.
Or visit us online at www.ntinfusioncenters.com