Intravene – Xolair Injection Orders (rev 4/2022)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 3001

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____
Height _____ Weight _____lbs
Drug Allergies_____
□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone(_____)_____
Physician Fax(____)_____
NPI#_____DEA#_____
State License#_____

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DIAGNOSIS (ICD-10 required)

- ☐ J45.40 Moderate persistent asthma, uncomplicated
- ☐ J45.50 Severe persistent asthma, uncomplicated
- ☐ _____
- ☐ _____

Other Asthma Therapies (tried and/or failed)	**Name of Drug**	**Date Failed**
□ Short–acting Beta-agonist	_____	_____
□ Inhaled Corticosteroids (without LABA)	_____	_____
□ Long-acting Beta-agonist (without ICS)	_____	_____
□ Combination Therapy (LABA/ICS)	_____	_____
□ Oral Steroids	_____	_____
□ Other (specify)	_____	_____

LAB RESULTS:

□ History of positive skin or RAST test to a perennial aeroallergen
Pretreatment serum IgE level IU/mL (1.0 kU/L=1.0 IU/mL; 2.4 ng/mL=1.0 IU/mL)_____ Test Date:_____
FEV1 Predicted Percent_____

PRESCRIPTION:

Prescription Type: □ Naïve patient □ Restart □ Continue therapy

Prescription Dispense XOLAIR

Subcutaneously, every 4 weeks
□ 150mg/dose
□ 300 mg/dose

Subcutaneously, every 2 weeks:
□ 225 mg/dose
□ 300 mg/dose
□ 375 mg/dose

Other Dose_____ Frequency_____

Duration: □ 1 year □ 6 months □ 3 months □ other_____

ANAPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD _____ Date _____