Intravene – Xolair for CIU 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)

- ☐ L50.1 Idiopathic urticaria
- ☐ _____
- ☐ _____
- ☐ _____

□ Patient has had CIU for 6 weeks or more

Other CIU therapies

□ H1 antihistamines
□ Other (specify):_____

PRESCRIPTION INFORMATION:

Prescription Type: □ Naïve patient □ Restart □ Continue treatment- Last injection_____

Prescription Dispense XOLAIR subcutaneously

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

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

ANAPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD _____ Date _____