OKLAHOMA INFUSION SERVICES

Xolair Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ J45.40 Moderate Persistent Asthma, Uncomplicated (6 years of age and older)
☐ J45.50 Severe Persistent Asthma, Uncomplicated (6 years of age and older) – *Uncontrolled with Inhaled Corticosteroid?* ☐ *Yes* ☐ *No*
☐ L50.1 Idiopathic Urticaria (12 years of age and older) – *Symptomatic Despite H1 Antihistamine Treatment for 6 weeks?* ☐ *Yes* ☐ *No*
☐ Other: Code: _____ Description: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ Date of last Xolair injection: _____
☐ Does patient have history of severe hypersensitivity reaction to previous dose of Xolair or any ingredient of Xolair? ☐ Yes ☐ No
☐ Has patient had positive skin test to perennial aeroallergen? ☐ Yes ☐ No Test Date: _____ Results: _____
☐ Has patient had positive RAST test? ☐ Yes ☐ No Test Date: _____ Results: _____
☐ Has patient had pre-treatment IgE serum? ☐ Yes ☐ No Test Date: _____ Level: _____

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ Total IgE
☐ Other _____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Xolair

Administration: ☐ Vial (Lyophilized Powder) ☐ PFS (Prefilled Syringe)
Dose: ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg ☐ Other _____ mg
Frequency: ☐ every 2 weeks ☐ every 4 weeks ☐ every _____ weeks

Note: Patient must have EpiPen in their possession on their appointment date.

Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP
☒ Tylenol tablet 500-1000mg PO PRN
☒ Benadryl 25mg PO PRN
☐ Other: _____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus
☒ Notify supervising physician and ordering provider
☒ Solu-Cortef 100mg SIVP signs of adverse reaction
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Oxygen 2-5L nasal cannula
☒ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

_____ _____

Prescriber's Signature: **Date:**

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

Please fax form to: 405-726-9849

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