

Patient Information

Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

Additional Information Needed

- | | | |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs |
| <input type="checkbox"/> Fax patient demographics | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> 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 Benadryl 25mg PO PRN
 Tylenol tablet 500-1000mg PO PRN Other: _____

Standing Orders for Adverse Reactions

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