

Xolair® (omalizumab) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 Code (required):	ICD-10 Description:	Last Treatment Date:
		Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

Reason patient cannot self-inject (fax supporting documentation for exception if applicable):

Cognitive impairment

Physical limitation (e.g., dexterity issues)

Lack of caregiver support

History of adverse reaction during self-administration

Patient preference after education

Other: _____

XOLAIR ADMINISTRATION

Dose:	75 mg	150 mg	225 mg
	300 mg	375 mg	450 mg
	525 mg	600 mg	

Frequency: every 2 weeks every 4 weeks

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

Pretreatment IgE Level (IU/ml) *Asthma, rhinosinusitis, food allergy indication*

Positive Skin or RAST test *Asthma, food allergy indication*

Provider Name (Print)

Provider Signature

Date

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	

Order is valid for one year unless otherwise noted.

Revision Date 01/2026