XOLAIR® (omalizumab) Referral Form

Patient Preferred Clinic (select one): _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order 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 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per Vivo protocols.

XOLAIR THERAPY ADMINISTRATION

Dose: ☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg

Frequency: ☐ every 2 weeks ☐ every 4 weeks

OTHER NOTES

REQUIRED DOCUMENTATION

- ☐ **Patient Demographics**
- ☐ **Insurance Card/Information**
- ☐ **Progress Notes Supporting DX**
- ☐ **Current Medication List and H&P**
- ☐ **Pretreatment IgE Level (IU/ml)** *Asthma indication*
- ☐ **Positive Skin or RAST test to a perennial allergen** *Asthma Indication*

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Fax Numbers

☐ Virginia: 804-500-5941	☐ Nevada: 702-489-5744	☐ Massachusetts: 800-540-1852
☐ Colorado: 303-418-4679	☐ New Jersey: 609-955-3711	☐ Pennsylvania: 215-399-9244
☐ Florida: 904-930-4211	☐ Ohio: 216-400-0674	☐ New York: 800-540-1852
☐ Texas: 469-340-0044	☐ Oklahoma: 918-770-4421	☐ Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: referrals@vivoinfusion.com

Email Specialty Referrals to: info@specialtyinfusion.com

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