

# XOLAIR® (omalizumab) Referral Form



**Preferred Clinic** (select one):

## PATIENT INFORMATION

**Referral Status:**    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:

## NURSING

Infusion to be administered per Vivo protocols.

## XOLAIR THERAPY ADMINISTRATION

<b>Dose:</b>	75 mg	150 mg	225 mg
	300 mg	375 mg	450 mg
	525 mg	600 mg	

## OTHER NOTES

**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*

\*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
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Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com) OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	