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 (kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Injection 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	

Referral is valid for one year unless otherwise noted.

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