



**Physician Signature:

XOLAIR (OMALIZUMAB) INJECTION ORDERS

REQUIRED INFORMATION			
☐ This signed order form from the provider ☐ Patient demographics & insurance information ☐ Clinical/Progress Notes, Labs & Tests supporting	ng primary d	iagnosis	
Patient Name:		DOB:	
Allergies:		Patient Phone:	
Diagnosis:			
☐ Allergic Asthma	(ICD-10:)		
☐ Chronic Idiopathic Urticaria	(ICD-10:)		
J Code: J2357			
Pt. Weight kg Allergies:			
	XOLAIR	ORDERS	
Xolair Dose: ☐ 150mg ☐ 250mg ☐ 300mg ☐ 375mg			
Frequency: Subcutaneously Every: □ 2 weeks or □ 4 weeks			
History of Allergic Asthma: Positive Skin or RAS Test Date:		Yes □No	
Pre-Treatment IgE Serum:		IU/ml Test Date:	
**Date of last Xolair Injection: Note: Patient must have and EpiPen in the possession on their appointment date.			
Additional Instructions:			
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Physician Name:		Phone:	Fax:

Date: