XOLAIR®Infusion Form

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Severe persistent asthma, uncomplicated
_____ Severe persistent asthma with acute exacerbation
_____ Persistent asthma with status asthmaticus
_____ Chronic Idiopathic Urticaria
_____ Other: _____

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis 2. Diagnostic testing documentation (Skin or RAST Test) 3. Copy of the patient's Insurance Card 4. Pre-Treatment IgE results

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **XOLAIR® (omalizumab)**

Xolair (omalizumab): _____ mg

New Start: _____ # Refills (Recommend 6 -8 Refills)

Administer subcutaneously every

☐ **2 weeks**
or
☐ **4 weeks**

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date