immersiv HEALTH

XOLAIR® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

- ☐ J33. ___ Nasal Polyps
- ☐ J45. ___ Persistent Asthma
- ☐ L50. ___ Urticaria
- ☐ Z91. ___ Food Allergy
- ☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- ☐ Insurance Information
- ☐ List of Medications
- ☐ Tried & Failed Therapies
- ☐ Most Recent History & Physical
- ☐ Pre-Treatment IgE levels
- ☐ Skin or RAST Test, if applicable

MEDICATION ORDER

***Please complete dose when selecting frequency**

- ☐ Xolair® (omalizumab) _____ mg via subcutaneous injection every 2 weeks
- ☐ Xolair® (omalizumab) _____ mg via subcutaneous injection every 4 weeks
- ☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Provider Attestation of need for HCP administration

- _____ INITIALS Patient has experienced severe hypersensitivity reactions to Xolair within the past 6 months and requires administration and direct monitoring by a healthcare professional.
- _____ INITIALS Patient or caregiver are not competent or are physically unable to administer the Xolair formulation labeled for self-administration.
- _____ INITIALS Patient has history of uncontrolled disease and in the clinical opinion of the ordering provider, it is not advisable to try the self-administered formulation of Xolair.
- _____ INITIALS The circumstances and location for self-administration are not adequate for the potential treatment of anaphylaxis.
- _____ INITIALS Patient's weight is such that in the clinical opinion of the ordering provider, it is not advisable to try the self-administered formulation of Xolair.

Patient to be observed for 30 minutes following the first injection and then for 15 minutes following each subsequent injection.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN