Provider Order Form

XOLAIR (OMALIZUMAB)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Allergic Asthma J45. _____ ☐ Chronic Spontaneous Urticaria L50. _____

☐ Chronic Rhinosinusitis with Nasal Polyps J33. _____ ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ XOLAIR (omalizumab), Subcutaneous Injection	☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg	☐ every 2 weeks ☐ every 4 weeks

Refills ☐ Zero ☐ 12 months ☐ _____. Order valid for 1 year unless otherwise stated. _____

☐ Patient is required to have Epi Pen with each treatment

☐ Patient is NOT required to have Epi Pen

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Serum IgE level and date resulted (results)

_____ _____

Provider Signature Date