AYSA
THERAPEUTICS INFUSION

XOLAIR (OMALIZUMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

J Code: J2357 Diagnosis: ☐ Persistent Asthma ICD-10 Code: _____

☐ Chronic Idiopathic Urticaria ICD-10 Code: _____

☐ Nasal Polyps ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

XOLAIR ORDERS

Xolair Dose: ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg ☐ 450mg ☐ 525mg ☐ 600mg

Frequency: Subcutaneously Every: ☐ 2 weeks or ☐ 4 weeks

History for Persistent Asthma: Positive Skin or RAST Test: ☐ Yes ☐ No

Test Date: _____

Pre-Treatment IgE Serum: _____ IU/mL Test Date: _____

** **Date of last Xolair Injection:** _____

Note: Patient must have an EpiPen in their possession on their appointment date.

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____