XOLAIR (OMALIZUMAB) Referral Form

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

XOLAIR MEDICATION ORDERS

Dosing: ☐ 375mg ☐ 300mg ☐ 225mg ☐ 150mg

Other: _____

Frequency: ☐ SC every 2 weeks ☐ SC every 4 weeks

INDICATION/DIAGNOSIS

☐ J45.40 Moderate persistent asthma, uncomplicated
☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Chronic Idiopathic Urticaria (CIU)
☐ ***Requirement: Patient has an unexpired EPI pen at time of injection and is competent in its use.***

***ICD-10 _____ required**

NOTES (ADDITIONAL INFO)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW *ASTHMA* REFERRALS ONLY)

☐ Positive Skin or RAST test to a perennial allergan ☐ Pretreatment IgE level 10/ml

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY