XOLAIR (OMALIZUMAB) Referral Form

FAX (855) 891-2191

Effective: 10/2016

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake

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

_____

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Name: _____

Specialty: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

Contact Email: _____

XOLAIR MEDICATION ORDERS

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

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

INDICATION/DIAGNOSIS

☐ Allergic Asthma
☐ 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 **valid for one year*

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